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Adolescent Today

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"Catch Them Early Keep Them Safe"

Theme : Identity Formation

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Editorial

Greetings from the Team of Adolescent Health Academy (AHA).

We are delighted to present the first issue of the year 2026. For this issue, we have chosen *Identity Formation* as the central theme—because discovering "Who am I?" is perhaps the most fundamental developmental task of adolescence. During these years, young people gradually move from identities shaped by family and childhood experiences toward identities that they define for themselves.

The journey of identity has been reflected in human stories across centuries. In the great Indian epic *Mahabharata, the story of Karna* offers a powerful reflection on this theme. Born to Kunti yet raised by a charioteer's family, Karna spent much of his life searching for a sense of belonging. Society often defined him by his circumstances, yet his inner strength drove him to define himself through courage, loyalty, and exceptional skill. *His life reminds us that identity is not merely inherited—it is shaped through experiences, choices, and resilience.*

In this issue, we explore the many dimensions of identity formation through diverse perspectives. We present an evidence-based article on identity formation and the changes occurring in the adolescent brain, helping us understand the neurobiological foundations of this developmental process. The issue also includes discussions on the social dimensions of identity formation, as well as valuable insights from a psychologist's perspective, highlighting the emotional and psychological pathways through which adolescents shape their sense of self.

Alongside the thematic focus, the issue also addresses several important physical health concerns of adolescents. Our contributors include specialists from different disciplines—such as a **gynecologist and an expert article addressing Asthma in Adolescents.** Another valuable contribution outlines practical steps for establishing **Adolescent-Friendly Clinics in Medical Colleges,** an initiative that can significantly strengthen adolescent healthcare services.

This year, we are excited to introduce a new interactive column where experts will respond to **questions directly raised by preteens and teens**. By giving space to their voices and curiosities, we hope to create a platform that encourages open dialogue and learning. I am overwhelmed to share a poem penned by a teenager which **beautifully captures a child's nostalgic yearning for the simple, comforting moments shared with parents during early years.**

Additionally, the Central AHA initiative to celebrate the **achievements of our members** finds a place in this issue, acknowledging the remarkable contributions of professionals dedicated to adolescent health.

Under the able guidance of our Chairperson, Dr. Sushma Desai, we hope that this journal continues to nurture thoughtful dialogue and meaningful engagement around the evolving world of adolescents.

Perhaps the questions of identity that Karna struggled with centuries ago still echo in the hearts of our adolescents today. Through this issue, we hope to deepen understanding, encourage compassionate care, and support young people as they discover their unique identities.

We hope you enjoy reading this issue and continue to join us in nurturing the health, confidence, and potential of our adolescents.

With warmth,
As we walk alongside our adolescents in their journey of becoming.

The Editorial team,
Dr. Poonam Bhatia (Chief Editor)
Dr. Sonia Bhatt (Editor)
Dr. Shubha Badami (Advisor)
Dr. Isha Singh (Sub Editor)
Dr. Shilpi Sidhanta (Sub Editor)
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Dr. Ranjeet P (Youth Editor)

Chairperson's message

Dear Fellow AHAians / IAPians and Readers,

It gives me immense pleasure to present the first issue of our quarterly journal, "Adolescent Today," for the year 2026! This publication marks an important milestone in our collective effort to strengthen awareness, knowledge, and practice in the field of adolescent health.

Adolescence is the most dynamic and the most "happening" phase of life, characterized by rapid physical & sexual, mental & emotional, psychosocial & spiritual changes, transforming a " child" into a completely independent functioning "Adult". As pediatricians and healthcare providers, our responsibility extends beyond addressing immediate health concerns—we must nurture a continuum of care that begins even before adolescence.

In this context, I would like to emphasize that promotion of pre-teen healthcare is equally vital. Early intervention during the pre-adolescent years lays a strong foundation for healthy transitions into adolescence and adulthood.

Our approach must therefore be comprehensive, integrating pre-teen, adolescent, and youth healthcare into a unified framework. Preventive care, mental health support, nutritional guidance, reproductive health education, and life-skill development should begin early and continue seamlessly across these stages. By doing so, we can better address emerging challenges and empower young individuals to make informed, healthy choices.

"Adolescent Today" aims to serve as a platform for sharing scientific knowledge, clinical experiences, innovative ideas, and best practices.

From the year 2026, we are incorporating a uniquely designed interactive section in the form of Questions & Answers. The queries and questions of the preteens, Adolescents & the young adults , as well as the parents, will be answered by the experts in the fields.

I encourage all members to actively contribute and engage, so that together we can advance the standards of care for our young population.

I extend my heartfelt gratitude to the editorial team under the Chief Editorship of Dr. Poonam Bhatia, along with the dynamic Team comprising of Dr. Shubha Badami, Dr. Sonia Bhatt,Dr. Amol Pawar, Dr. Ranjith, Dr. Isha Singh, and the most dynamic Webmaster, Dr. Samir Shah, for their tireless efforts, unique creativity and dedication in bringing out this first issue. I am confident that this journal will grow into a valuable resource for all professionals committed to adolescent and youth health.

Let us continue to work collaboratively towards building a healthier future—starting from the pre-teen years and extending across the entire spectrum of adolescent and youth care.

With Warm regards,
Dr. Sushma Desai,
The Chairperson AHA IAP 2026

Message from AHA Honorary Secretary

It gives me immense pleasure and a deep sense of purpose to present the inaugural issue of Adolescent Today Journal in 2026, a landmark initiative of the Adolescent Health Academy. This journal represents not merely a publication, but a collective commitment—an intellectual and ethical pledge—to prioritize, understand, and advocate for the multifaceted health needs of adolescents in an ever-evolving world.

Adolescence is a dynamic and transformative phase of life, characterized by rapid physical, emotional, cognitive, and social changes.

In today's context, this journey is further influenced by unprecedented challenges and opportunities—ranging from digital exposure and mental health concerns to shifting societal norms and emerging health risks. These complexities demand a dedicated, evidence-based, and multidisciplinary approach, which this journal seeks to embody.

Adolescent Today Journal has been envisioned as a platform that bridges clinical practice, academic research, public health policy, and grassroots experiences. It aims to foster dialogue among pediatricians, psychiatrists, psychologists, educators, social workers, and policymakers, while also amplifying the voices of adolescents themselves. By integrating scientific rigor with practical insights, we hope to contribute meaningfully to improving adolescent health outcomes across diverse settings.

The launch of this journal also underscores the Academy's commitment to nurturing a culture of inquiry and innovation.

We encourage contributions that explore not only conventional domains such as nutrition, reproductive health, and mental well-being, but also contemporary themes like digital addiction, cyber safety, gender identity, climate anxiety, and resilience building. In doing so, we aspire to remain relevant and responsive to the evolving realities faced by young people today.

This initiative would not have been possible without the dedication and vision of our editorial board led by Dr. Poonam Bhatia contributors, and supporters who have worked tirelessly to bring this idea to fruition. I extend my heartfelt gratitude to each one of them.

Their passion and perseverance have laid a strong foundation for what we hope will become a respected and impactful voice in adolescent health discourse.

As we embark on this journey, we remain guided by a simple yet profound belief—that investing in adolescent health is investing in the future of society. Through this journal, we aim to inspire collaboration, inform practice, and influence policy, ultimately empowering adolescents to thrive as healthy, confident, and responsible individuals.

I invite all stakeholders to actively engage with Adolescent Today Journal—as readers, contributors, and advocates. Together, let us shape a future where every adolescent is supported, understood, and given the opportunity to realize their fullest potential.

With warm regards and best wishes for this new beginning,

Dr. Shamik Ghosh
Honorary Secretary
Adolescent Health Academy
2026-2027

Scientific Dimensions of Adolescent Identity Development

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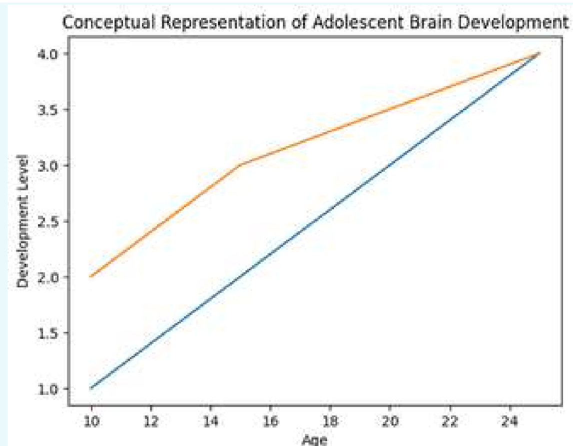
Introduction :

Adolescence is a critical developmental stage characterized by profound biological, psychological, and social transformations. During this period, individuals begin to construct a coherent sense of identity—an understanding of who they are, what they believe, and their role in society.

Identity development is not merely a social phenomenon but a complex process influenced by neurobiological maturation, cognitive growth, emotional regulation, and environmental interactions.

Scientific research across pediatrics, psychology, and neuroscience has significantly advanced our understanding of how adolescents develop identity and how this process impacts long-term health and well-being.

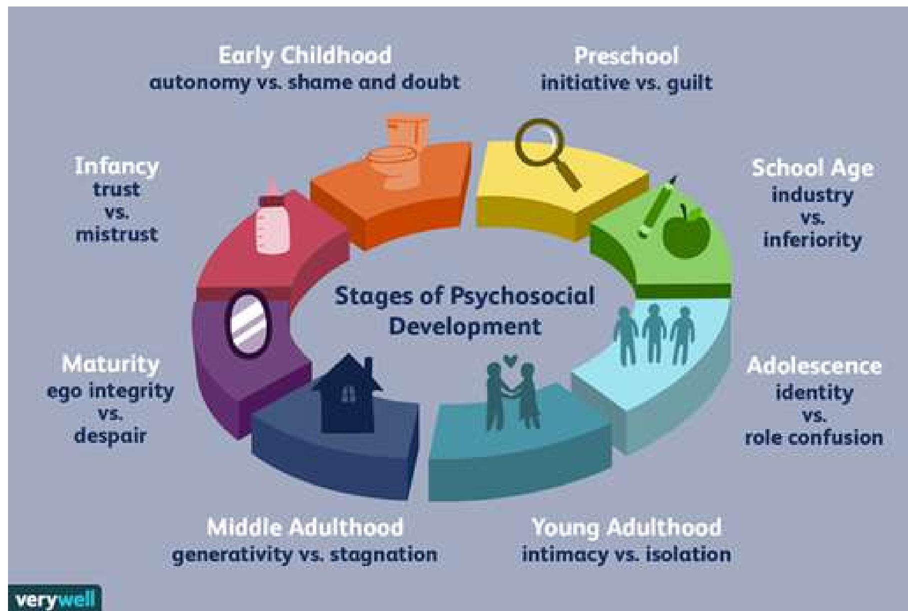


Neurobiological Foundations of Identity Development:

Adolescence is marked by dynamic changes in brain structure and function. Neuroimaging studies show that the prefrontal cortex, responsible for decision-making, impulse control, and long-term planning, continues to mature into the mid-twenties. In contrast, the limbic system, which regulates emotions and reward processing, develops earlier.

This developmental imbalance contributes to characteristic adolescent behaviors such as risk-taking, sensation seeking, and emotional intensity. These neural processes play an important role in identity exploration. Adolescents experiment with beliefs, relationships, and social roles as part of normal brain-driven developmental processes.

Synaptic pruning and increased myelination enhance neural efficiency, allowing adolescents to develop more complex reasoning and self-reflection abilities. These biological mechanisms enable young individuals to evaluate personal values, moral beliefs, and future aspirations—key elements of identity formation.



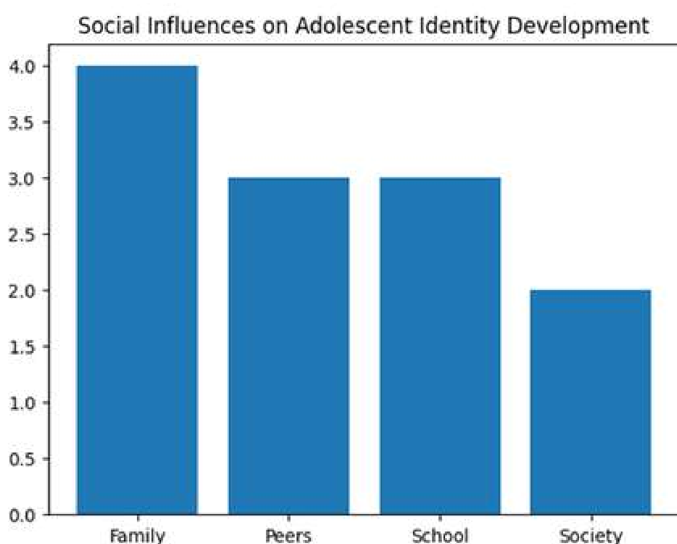
Cognitive Development and Self-Concept:

Cognitive development during adolescence allows individuals to think abstractly, consider hypothetical situations, and reflect on their own thoughts. These abilities support the emergence of metacognition, or thinking about one's own thinking.

Developmental psychologist Erik Erikson described adolescence as the stage of Identity vs. Role Confusion. According to his theory, adolescents explore different roles, values, and goals in order to establish a stable sense of self. Failure to resolve this stage may lead to uncertainty or identity confusion.

Modern research expands on this concept by describing four identity statuses: identity achievement, moratorium, foreclosure, and identity diffusion. Healthy identity formation typically involves a period of exploration where adolescents test various roles before making long-term commitments.

Social and Environmental Influences:



Identity development does not occur in isolation; it is shaped by multiple environmental contexts including family, peers, school, and culture.

Family influence plays a foundational role. Supportive parenting that encourages autonomy while maintaining emotional connection promotes healthy identity exploration. Adolescents from families that foster open communication often demonstrate stronger self-esteem and decision-making skills.

Peer relationships become increasingly significant during adolescence. Peer groups provide opportunities for social comparison, acceptance, and experimentation with roles. Positive peer relationships support identity formation, whereas negative influences may increase risk behaviors.

Educational and societal environments also shape identity. Exposure to diverse ideas, mentors, and opportunities allows adolescents to explore academic interests, career aspirations, and social values.

Role of Pediatricians in Adolescent Identity Development:

Pediatricians and adolescent health specialists play a crucial role in supporting healthy identity development. Clinical interactions during adolescence provide opportunities to address psychosocial issues, encourage positive decision-making, and identify early signs of mental health concerns.

Effective strategies include creating adolescent-friendly healthcare environments, ensuring confidential consultations, providing mental health screening, encouraging healthy lifestyle behaviors, and supporting career and life goal discussions.

Holistic adolescent healthcare integrates biological, psychological, and social dimensions of development. Pediatricians can guide adolescents toward healthy identity formation by fostering resilience, self-confidence, and responsible independence.

Conclusion:

Adolescent identity development is a multifaceted process shaped by neurobiological maturation, cognitive advancement, emotional regulation, and social interactions. Scientific evidence highlights that adolescence is a period of exploration rather than instability. Through supportive family structures, positive peer relationships, educational opportunities, and responsive healthcare systems, adolescents can successfully develop a stable and healthy sense of self.

Understanding the scientific dimensions of identity formation enables pediatricians, educators, and policymakers to design interventions that promote adolescent well-being and prepare young individuals for responsible adulthood.

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Identity Formation in Children: Social and Cultural Issues

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The question "Who am I?" begins to be answered in the earliest years of life. Identity formation—the development of a coherent sense of values, roles, and belonging—is a dynamic process shaped by an intricate web of relationships, cultural environments, and lived experiences.

Theoretical Foundations

Three primary frameworks help explain this journey:

- Erik Erikson's Psychosocial Theory: Identity unfolds in stages. From learning if their desires are acceptable (ages 3–5) to measuring themselves against social standards (ages 6–12), children eventually reach the "identity versus role confusion" stage in adolescence.
- Social Identity Theory (Tajfel & Turner): Children derive self-concept from group memberships (race, gender, religion). When they perceive their group is devalued by society, it directly impacts their self-esteem.
- Vygotsky's Sociocultural Theory: Identity is a "social product." Children internalize the language and values of their culture through interactions with caregivers and peers.

The Primary Spheres of Influence

1. The Family and Cultural Transmission

- The family is the first arena of identity. Secure attachment provides the psychological safety necessary for exploration. Families act as the primary transmitters of culture through language, rituals, and storytelling.
- The Bicultural Struggle: In immigrant families, children often perform a balancing act between the "home culture" and the "host society," navigating different value systems simultaneously.

2. Peers and Social Comparison

- As children enter school, peers become powerful mirrors. Children are acutely sensitive to social ranking.
- **Play as Exploration:** Imaginative play allows children to "try on" different roles safely.
- **The Pain of Exclusion:** In middle childhood, social hierarchies become rigid. Children from marginalized groups often bear the "additional burden" of navigating stigma or bullying based on perceived differences.

3. Gender and Social Class

- **Gender**: By age two or three, most children have a basic gender identity. By middle childhood, peer groups often rigidly police gender norms, censuring those who deviate from conventional expressions.
- **Socioeconomic Status:** Children from economically marginalized backgrounds often develop an acute awareness of material inequality. This can manifest as shame or resentment, often reinforced by schools that unintentionally reproduce class hierarchies.

Identity in the Digital Age

Technology has introduced "Algorithmic Identity." Commercial algorithms, rather than parents or educators, now curate the values and role models children see.

- The Double-Edged Sword: While social media can fuel anxiety through constant comparison, it also provides "affirming spaces" for LGBTQ+ youth or ethnic minorities who may feel isolated in their physical communities.

Institutional and Multicultural Issues

Education and Media act as secondary sites of identity formation. When a school curriculum centers on a single tradition, it marginalizes those outside of it. Conversely, seeing one's history reflected in lessons boosts engagement and self-worth.

- Bicultural Identity and Code-Switching: Many children become adept at "code-switching"—altering their behavior and speech to fit different cultural contexts. While this fosters cognitive flexibility and empathy, the constant management of "which self to present" can be psychologically exhausting.

Challenges and Protective Factors

Children facing identity threat (stigma or discrimination) are at higher risk for anxiety and "identity foreclosure"—adopting a restricted, externally imposed self to survive.

Pathways to Healthy Development:

- Cultural Rootedness: Strong family bonds and pride in heritage.
- Inclusive Environments: Schools and communities that celebrate diversity.
- Critical Literacy: Teaching children to question media messages.
- Mentorship: Access to role models who share and validate the child's identity.

Conclusion

Identity is not a solitary act; it is a social process entwined with power and representation. A child's answer to "Who am I?" depends heavily on what the world allows them to become. The moral imperative for society is to ensure that environments—from the home to the digital screen—open possibilities rather than close them down.

Identity Development in Adolescence

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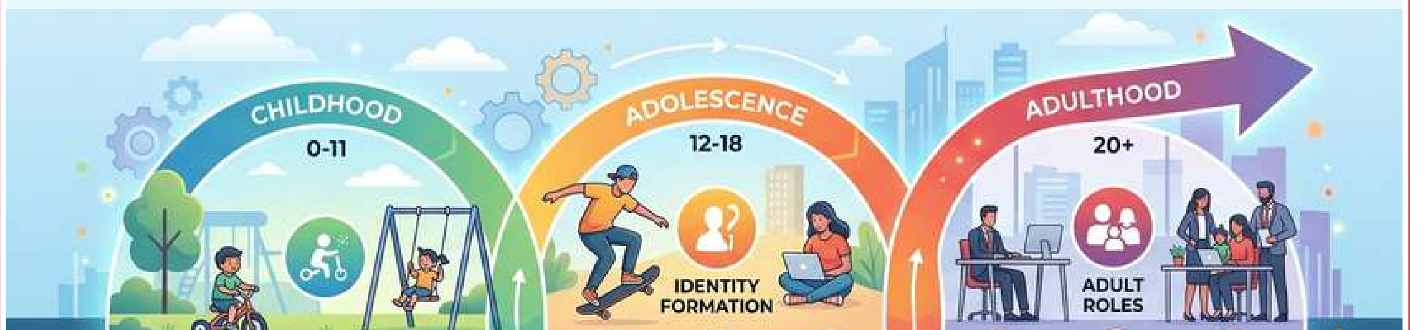
Adolescence, between 10-19 years, is the age group that sees the transition from child to adolescence to adulthood. During this critical period, they undergo various changes, involving biological, psychological and social aspects. Hence, this becomes a crucial period in their development.



There are many significant changes happening in the adolescent brain.

Following birth in children, it is the maturation of primary sensorimotor cortex which happens first and maturation of pre-frontal cortex happens the last as they enter adulthood. So, the subcortical regions which develop relatively earlier, tend to cause an imbalance in adolescence with more mature subcortical regions and relatively less mature prefrontal regions.

This at one end leads to intellectual and emotional development in adolescence. But the imbalance predisposes them to more risk-taking behaviors [1] The neuroscience studies in the recent years provide additional information on the brain development in the adolescence indicating that there is important neuronal remodelling happening involving synaptic pruning, myelination, enhanced connectivity changes in the white matter between two hemispheres. All the above leads to neuroplasticity which provides the brain a enhanced capacity to adapt to experiences and a foundation for cognitive learning required for independence as an adult [2].

From a cognitive developmental angle, the adolescent starts to think abstractly, use hypothetical thinking and more of deductive logic as described in "formal operational stage" by Piaget. Through the various changes described above and with important psychosocial changes involving education, exploring one's interests, choosing a career, to exploring relationships outside the family circle – involving friends and romantic relationships – all of these influence how an individual perceives oneself.

The concept of “Identity” described as – **“one’s sense of the person one genuinely is, including a subjective feeling of sameness and continuity over contexts and time”** [3].

Erikson’s psychosocial stages of development lays emphasis on **“Identity vs. role confusion”** during adolescence. It is described that those who positively adapt through this stage and develop an identity, gives them the virtue of fidelity. It is said that with a stronger development of identity, the better handling of self and external environment arises, leading to decreased anxiety and dismissing unwanted evaluation of self [4].

Marcia’s **Identity Development Model** further expands on Eriksons theory and defines four identity statuses based on levels of exploration and commitment regarding occupation, ideology and values. They are as follows:

1. **Identity Achievement** *(High exploration and high commitment)*: If both identity exploration and commitment have been adequately attained.

2. **Foreclosure** *(Low exploration and high commitment)*: This happens when there is no adequate exploration and going in to commitment often as under the influence of parents in Indian context.

3. **Moratorium** *(High exploration and low commitment)*: This happens when there is excess exploration, experimenting without coming into a commitment.

4. **Identity Diffusion** *(Low exploration and low commitment)*: This happens when there is no active exploration or unwillingness for a commitment.

“Dual cycle model” further describes identity formation focusing on dynamic and ongoing processes, in two cycles namely, “identity formation cycle” and “identity maintenance cycle”. During the **“Identity formation cycle”** adolescence explore various identity alternatives and form an identity commitment. This is described as an in-breath exploration evaluating various options available.

Whereas during the **“Identity maintenance cycle”** there is maintenance of the commitment along with in-depth evaluation of the chosen option in a dynamic fashion. Which means there would be continued evaluation of the chosen commitment and if one feels increased uncertainty about the commitment, they may reconsider and go back to “Identity formation cycle” to form a clearer and strong commitment [5].

This clarity in self-concept or the extent to which one describes themselves consistently has been discussed as one of the key factors leading to strong personal identity.

Identity development continues into adulthood :

In the current circumstances, as a result of prolonged education most of them are having to depend on parents, which leads to delay in attaining independence professionally and committing for personal relationships and family life. Hence, a possible delay in commitment to the personal identity.

It is also been consistently noted that adolescents with identity uncertainty are more likely to develop higher levels of anxiety and depressive symptoms in later life. Vis-à-vis **those with stable identity commitment have shown to have higher levels of psychosocial adaptation,** higher self-esteem and life satisfaction on the whole. Hence, reiterating the importance of healthy adolescent identity development.

The current modern society is seeing a lot of transformation ranging from educational, economical, and broader socio-cultural aspects. It comes with certain negatives as well as positives that might affect the adolescence identity development. There is decrease in joint families and uniform tradition and cultures, which possibly served as internal buffers in the olden society. There is more encouragement for completing basic education, better parenting styles, reduction in taboo around menstruation, more access to resources, health and information. With this constantly changing societal system, it is important to inculcate values, uphold the strengths of adolescence, make basic life skills education as part of curriculum, and support the adolescence through this sensitive period for a healthier identity development which will help them in long run.

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Relationships in Today's Teens and Youth

(Becoming, Belonging and Being)

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Reeta (19 years) studies in a reputed engineering college. She was in a relationship with her classmate and soon they got into unprotected intimacies multiple times in six months. Recently her boyfriend has lost interest in her because she is too possessive and inquisitive.

Rita realised this and begged him many times but he has blocked her mobile chats which made her very much sad, angry and frustrated.

Rita could not revive the relationship and now blames herself for being so stupid to lose her virginity to such a person. She is labelled as a "cheap girl" in the college and has taken to drugs with attempts of self-harm twice in last two weeks.

The above case reveals a very common story in today's teens and youth where the girls suffer from physical, mental and social consequences more than the boys.

Most teenagers fail to understand the difference between love and attraction owing to negligent parenting, ignorance and facilitative peer influence.

Many teenagers, especially in urban areas, believe that permanence is not essential to form a bond. A significant number of them have multiple, shifting, intimate and casual relationships.

The age-old personal, mutual and social demand of converting an affair into marriage is gradually being deserted. Both partners are apparently comfortable about such liaisons and no one (ostensibly) blames self or the other person for his/her past or future plans.

Typical dimensions and spectrum of current relationship status in youth are depicted below:

Status	Features	How common?	Sequelae
Single status	Happy to be alone	Not rare	Relatively safe
Crush	Longing for bodily pleasures	Quite common prior to pre-frontalization	Physical, mental and social consequences.
True love	Commitment with family involvement	On the decline	Mutual growth and future plans.
Married couple	Conflicts with belonging	Communal	Family life.
"Situation ship"	Attraction but with consensus to have another boy/girlfriend	Very common	Not much emotive connection between the partners.
Compatibility testing	Pre-wedding intimacies to know one another's sexual capacities, preferences and behaviours	On the rise both in love and arranged marriages	Usually uneventful but there is nothing new after marriage.

Factors in adolescent sexual activities:

1. Increased desire and libido.
2. Tendency to experiment.
3. Ignorance due to lack of sexuality education by gatekeepers.
4. Unplanned casual sexual encounters.
5. Low/wrongful contraception usage.
6. Peer pressure.
7. Coercive sex.
8. Partner may be high risk.
9. Multi-partner sex.
10. Concurrent substance abuse (mainly alcohol)

Thus, the emotional, devotional, futuristic and family-oriented aspect of a relationship amongst young people is gradually fading. The concept of "a sweet home with family", emotional sensitivity, the ecstatic feeling of togetherness and belonging are labelled as "outdated" by today's youth. Fun and pleasure dominate over commitment and long-term planning. The long-term implications of these sporty affairs remain unknown.

It must be remembered, however, that the girl may suffer more than the boy if there are complications like S.T.I. or pregnancy. For a boy, having multiple physical liaisons may become an 'asset' and a reason to boast about his maleness but a girl with many intimate friends in the past may be labeled as a 'slut' or a girl with bad character. Such a girl may not be able to find a partner with long term commitment. This is especially true in India, where family and societal norms still have an upper hand over individual choice.

The reasons for this attitudinal change of young generation could be disturbed parental relationships, influence of media, peer pressure, easy opportunities (latch-key homes with nuclear/single parent families) or a combination of all these. The liberal concurrent substance abuse aggravates unprotected penetrative sexual practices with emergency contraceptive pills as the commonly employed unsafe precaution.

There are various reasons for a ‘break-up’ in young couples. A few of these are excessive possessiveness/demands, loss of interest, finding a new (cooler) partner, betrayal, interference by peers, parental/teacher’s restrictions or realisation that “it was a mistake”. The reactions to a break-up in a relationship can present as sheer indifference with late realisation of emotional trauma, extreme sadness with drug abuse/suicidal thoughts or unhealthy anger/revengefulness by taking to physical harm or defamation of the friend.

When such a teenager comes to us for counselling, our approach should focus on converting unhealthy to healthy negative emotions (e.g., guilt into regret/remorse or depression into sadness or unhealthy destructive anger to assertiveness). The principal goal should be to enable a disturbed teenager to grow to his/her maximum potential and be futuristic. This is achievable through a fruitful counselling session with various tools and techniques of rational emotive behaviour therapy (REBT).

Tasks for the parents: Teenagers are often perplexed about the concepts of a relationship and it an imperative duty of parents, teachers and peer educators to clarify these doubts. What appears to belove might just turn out to be sheer attraction which is a part of growing up, especially in early and middle adolescence. The sooner adults discuss these issues by using open ended questions and non-verbal communication skills, the better. Following diagram might clear these confusions.

Crush/Lust	True Love
• Short lived commitment	• Near lifetime commitment
• Focus on present only	• Plans for mutual growth
• Family avoidance	• Family sharing
• Self protection in crisis	• Protection of partner first
• Aims at sexual pleasures	• Aims at mutual fulfillment

Another task for parents is to create good examples of healthy relationships themselves. It has been observed that casual, multiple, non-lasting yet high-risk relationships are common amongst teens with disturbed home milieu and constant parental conflicts.

The probable future of family:

A significant number of today's youth decide to remain single. The reasons could be that we have failed to present an example of 'good' married life, an unwillingness to take the responsibilities of commitment, or anxiety and uncertainty about their partner's or their own destiny. Those who do marry, may dream about an extravagant wedding, without being ready to accept the ups and downs of a marriage. Down the line, we may have single person families with multiple impermanent relationships along with all the worldly conveniences, without peace of mind and devoid of a sense of belonging and bliss.

The fun of any relationship lies in allowing it to slowly and spontaneously unfold. The ecstasy of eye contact in a crowded home/wedding hall and the thrill of the unplanned touch… The haste of coming too close before there is any emotive connect and commitment, takes away this heavenly pleasure. Let the couple understand one another's needs, interests and mutual contributions towards fostering the virtuous gift of human relationships.

Becoming: Today's teens have enormous potential to become creative and constructive both for self and the world, provided they do not fall prey to unhealthy habits and are resilient enough to rise above break-ups and other stresses of growing up.

Belonging: Although they find gatekeepers are restrictive and irritating, they still wish to be in touch with us. The right approach is to have a good connect with them right from their childhood and pre-adolescent age.

Being: Today's baffled teens and pre-teens experience multiple stresses, including relationship issues. The times are more competitive and challenging than ours. Let them grow and become resilient to handle these. As parents, we need to provide "social vaccination" to our children in the form of life skills and healthy living habits.

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Case Discussion : Identity Formation

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Identity formation in pre-teens and adolescents refers to the process through which young people develop a clear sense of who they are, what they believe in, and how they see themselves in society.

It includes forming values, goals, beliefs, roles, and personal identity

Case Scenario 1

In my adolescent clinic, a 16-year-old girl, Riya, studying in Class XI (Science), was brought by her mother with the complaint of "sudden behaviour change."

Her mother appeared quite anxious and began the consultation by saying, - ***"Doctor, she is no longer the same obedient girl. She argues with us, she has changed her dressing style, cut her hair short, and is constantly on social media. I feel she is losing our family values."***

When I asked Riya how she felt about these concerns, she calmly replied,
"I just want to be myself. Why can't I decide my own future?"

Riya belongs to a close-knit family with one sibling. According to her parents, conflicts had increased over the past few months regarding career choices, clothing style, and friendships.

Her parents want her to prepare for NEET, but Riya expressed a strong desire to pursue Fine Arts. She had also recently become more active on social media and followed several lifestyle and art influencers.

Since behavioural concerns in adolescents often require a structured psychosocial assessment, I proceeded with a confidential HEEADSSS assessment.

HEEADSSS Assessment

H	**Home**	Riya reported that she generally has a supportive family environment, but arguments with her parents have increased recently, mostly regarding her career choices and personal preferences. Her parents perceive her assertiveness as disobedience.
E	**Education**	She is studying in Class XI (Science) with average academic performance. She shared that although she is managing her studies, she feels no intrinsic interest in pursuing medicine and instead wishes to pursue Fine Arts.
E	**Eating**	Her eating habits were normal. There were no concerns regarding body image or disordered eating.
A	**Activities**	Riya spends time on social media platforms, particularly following art and lifestyle influencers. She also enjoys sketching and creative activities, which she considers an important part of her identity.
D	**Drugs**	There was no history of tobacco, alcohol, or substance use.
S	**Sexuality**	She denied any risky sexual behaviour or relationship concerns.
S	**Suicide / Depression**	Riya did not report depressive symptoms, self-harm ideation, or emotional withdrawal. Her sleep, mood, and energy levels were normal.
S	**Safety**	No concerns regarding bullying, abuse, or unsafe situations were identified.

Clinical Interpretation

After completing the HEEADSSS assessment, it became evident that:

- There were no pathological features
- No evidence of substance use
- No academic deterioration
- No depressive symptoms
- No high-risk behaviours

Instead, Riya appeared to be exploring her personal preferences, values, and future goals, which had led to disagreements with her parents.

Counselling Approach

Conversation with Riya

I first acknowledged her feelings and explained that questioning, experimenting with roles, and expressing opinions are common during adolescence.

We discussed the importance of:

- Reflecting on long-term goals
- Communicating respectfully with parents
- Understanding that independence and family connection can coexist

I suggested that she consider career aptitude assessment and begin exploring structured pathways in Fine Arts, so that her aspirations could be discussed more concretely with her parents.

Counselling the Parents

I then spoke with her parents and reassured them that such changes are common during adolescence.

I explained that:

- Adolescents naturally begin to develop their own identity
- Assertiveness should not be immediately interpreted as rebellion or loss of values
- Excessive control may actually intensify conflict

They were encouraged to:

- Shift from control to guidance
- Engage in open discussions
- Consider career aptitude testing rather than imposing a predetermined career path
- Maintain family values while allowing gradual autonomy

Clinical Reflection

In situations like Riya's, what appears to parents as rebellion is often actually a young person trying to understand who they are and what they want to become.

Adolescents often experiment with:

- personal style
- career aspirations
- belief systems
- autonomy in decision-making

This process represents the developmental stage of identity formation.

When families are supported to respond with balanced guidance rather than rigid control, adolescents are more likely to develop a healthy and stable sense of identity.

Case Scenario 2

In my Adolescent Clinic , Arjun, a 17-year-old boy from a middle-class family studying in Class XII (Commerce), was brought by his father due to "attitude problems."

A worried Arjun's father begins the conversation by saying,

"He is becoming stubborn. Boys in our family take responsibility early, but he refuses to join the family business after Class XII. He wants to pursue sports management and train professionally in football."

"He is spending more time in the gym and with friends."

"He has recently become politically vocal on social media. He dresses differently from traditional family norms."

When he is asked about his father's worries, Arjun says: "Why should I live someone else's life?"

Arjun argues about "freedom" and "living life on my own terms."

Arjun belongs to a conservative middle-class family. His parents want him to join the family business, but he refuses to honour their wishes. Rather, he wants to pursue a career in sports in all seriousness.

Recently, he is voicing his political opinions on social media, which are sometimes radical. Arjun is trying to break away from traditional norms by dressing differently.

As Arjun is facing some specific Identity pressures which are common during adolescence, I proceeded for a confidential HEEADSSS assessment.

HEEADSSS Assessment

H	**Home**	Arjun says that his family is conservative and traditional. Recently there has been a conflict with his parents on mainly career choices and personal preferences .His parents perceive this as an act of disrespect.
E	**Education**	He is studying in Class 12(Commerce)He does not have any inclination to pursue higher studies. Nor does he want to join the family business. Instead he wants to become a professional footballer and be involved in sports management.
E	**Eating**	His eating habits were normal. There were no concerns regarding body image or disordered eating.
A	**Activities**	He is spending more time in the gym and also with friends. Recently he has become vocal on the social media with his political views.
D	**Drugs**	There was no history of tobacco, alcohol, or substance use.
S	**Sexuality**	Arjun denies having any risky sexual behaviour or any relationship issues.
S	**Suicide / Depression**	Although he confessed to being irritable sometimes, he did not have any depressive symptoms, suicidal ideation, or social withdrawal. His sleep and energy levels were normal.
S	**Safety**	No concerns regarding abuse or bullying.No unsafe situations or incidents were reported.

Clinical Interpretation

After the HEEADSSS assessment, it is clear that Arjun is struggling between a traditional masculine role and modern individualistic aspirations. He is trying to establish his identity through sporting activities. He is also trying to establish an ideological identity online and comparing with influencers.

Arjun's family follows a patriarchial and hierarchy-based – most likely Authoratarian parenting. Arjun's generation is getting increasingly exposed to global autonomy values and Western career models. This is leading to a conflict with parents especially with his father – leading to an intergenerational value clash.

Counselling Approach

Conversation with Arjun

I first acknowledged that Identity conflict is common in late adolescence.

Having personal preferences and own political views are normal for a person in late adolescence.

We discussed on the following :

- To focus on long term goals with skill mapping.
- To be aware of prudent financial planning
- To learn life skills like negotiation skills with parents.

I proposed that Arjun can analyse the risk-benefit ratio of his actions in life.

Counselling the Parents

I explained that Arjun’s assertiveness is not necessarily showing disrespect to his parents – it is often Identity formation in adolescents.

I discussed that responsibility should not be thrust upon Arjun –it should come gradually. Achieving success in life is diverse, and Arjun should be encouraged in getting to his goals.

I proposed to them that a trial period be given to achieve their goals – at the same time to set datelines for decision making.Also to have a backup plan in case Arjun meets with failure.

I stressed communication. They could listen patiently, have frequent family meetings, and never use accusatory language. Arjun can be corrected gently with appropriate reasoning.

Clinical Reflection

In cases like Arjun’s what appears as disrespect to parents is actually the adolescent trying to establish his own identity in his own way.

He is trying to develop a clear sense of who they are, what they believe in, and how they see themselves in society. It includes forming values, goals, beliefs, roles, and personal identity.

Identity conflict is common in late adolescence

- Boys may express distress as anger and not sadness, as expected generally.
- Career and masculinity are tightly linked in Indian males.
- Balanced negotiation often prevents rebellion in families.

In conclusion, we the clinicians, can act as a mediator, not a judge to give the adolescents a healthy life holistically.

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Parental Role in Positive Identity in Adolescents

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'Who am I?' is a universal question that has challenged individuals across the ages and cultures. Adolescence marks a transformative phase, not only characterised by physical, mental, and hormonal changes, but also by the quest to answer this fundamental question. The clarity gained from this journey empowers a confused youth to confidently step into adulthood.

Following infancy, adolescence emerges as the most pivotal developmental stage in shaping human potential. The adolescent brain is highly sensitive to environmental influences, and relationships during this period can have lasting effects on brain structure and cognitive development.

Identity Formation

Psychologists recognise identity formation as a core task of adolescent development. This process involves two main steps: exploration and commitment. Exploration entails adolescents trying out new identities and roles, often independent from family and influenced by peers. Through this process, they test various ideas and roles, ultimately identifying a few as their core values. Many ideas are discarded, while others reaffirm cultural roots. Commitment occurs when these ideas and roles become integral to personal beliefs, values, and goals.

A positive identity is crucial for the well-being and self-esteem of adolescents. It provides confidence to face challenges and self-worth to maintain resilience despite setbacks. This capability to adapt positively to difficulties fosters resilience, which is essential later in life.

Confident adolescents engage in protective and affirming relationships with peers, which facilitates the development of social connectedness required to navigate life's ups and downs. An individual with a positive identity is better equipped to manage thoughts, emotions, and external stressors. Such adolescents can transcend gender norms and cultural stereotypes, cultivating connectedness in a multicultural environment.

Unresolved identity crises manifest as internal and external friction, resulting in **Identity Confusion.** Internalising a negative identity increases vulnerability to stress, anxiety, emotional instability, and a lack of clear self-concept. Externalising behaviours due to negative identity can lead to hostility, aggression, loss of control, and susceptibility to negative peer influences.

The Parental Role

While the influence of parents may diminish during adolescence compared to early childhood, they remain key contributors to identity formation. Parenting approaches must evolve to meet the needs of adolescents. In childhood, secure attachments, boundaries, consequences, and controlled socialisation are important.

However, during adolescence, the approach shifts towards nurturing connection, collaborative decision-making regarding boundaries and consequences, and active monitoring without excessive control. Adolescents need greater autonomy in decision-making, and parents must transition from detailed instructions to gentle guidance, providing positive feedback through appreciation and respect.

Understanding and embracing the changed parental role is essential for fostering positive identity in adolescents. The earlier focus on correcting weaknesses must shift towards a strength-based approach. Problem-solving should aim for goals using strengths, with emphasis on appreciating achievements and abilities rather than merely correcting errors.

Actions for Parents

Positive Discipline: Accept mistakes and guide

Disciplinary structures from early childhood must evolve to teach self-regulation and executive functioning. Expecting unquestioned compliance is detrimental to adolescent self-esteem. Rules about consequences should be jointly agreed before infractions occur. Parents must model non-violent conflict resolution, and meaningful behavioural change arises when adolescents participate in the process. Coercive behaviour changes harms self-identity, and parents should accept short-term failures as part of developing lifelong skills and self-esteem.

Effective Communication and Engagement

Parents should refine their communication style by being active listeners and encouraging adolescents to share. During the identity exploration phase, sustained interest and attention are vital, even in periods of defiance. Communication bonds are especially tested on sensitive topics such as mental health and sexuality. Respectful communication creates safe spaces for such discussions and must consider adolescents' need for independence and privacy, with language and tone mindful of their maturing perspectives.

Promoting Safety: Offline and Online

As adolescents spend more time outside the home, parents must remain aware of their whereabouts without imposing restrictive control. Open discussions about safety and access to support services are important as independence grows. In the modern age, creating a safe environment extends to digital spaces, making family media plans with agreed limits and privacy rules essential.

Encourage expression along with Responsibility

Parents should encourage adolescents to voice opinions on matters affecting them, facilitating gradual transfer of responsibility. Age-appropriate engagement promotes critical thinking outside the home, and adolescents should not fear harsh judgment when expressing opinions. Disagreements must be openly discussed without labelling adolescents as immature.

Adolescent views should be respected unless the consequences are substantial. If parents need to act contrary to adolescents' wishes, they must explain their reasoning respectfully. Involving adolescents in decisions and gradually taking a backseat as they mature is recommended.

Encourage Exploration while understanding Consequences

Parents must recognise that some degree of chaos is inherent to adolescence, with shifting likes, peers, and choices reflecting the exploration phase. Rather than steering the ship, parents should act as a lighthouse, offering assurance and guidance during their adolescent's journey.

Unwavering Love and Support

The ultimate parental role is to serve as a stable soundboard, offering unwavering love, especially during inevitable phases of self-doubt. In challenging times, adolescents need to know their parents love and believe in them.

The journey of adolescence is one of becoming the expert of one's own life. Parents are facilitators in this process, and their stable presence provides the psychological security necessary for adolescents to confidently embrace their identity and declare, **"This is who I am."**

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A Cross Sectional Survey Among Preteens

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Introduction

Early adolescence represents a formative developmental stage characterized by rapid neurocognitive and psychosocial changes (5,7). Emotional regulation, autonomy, and executive functioning mature progressively during this period, influencing long-term behavioural trajectories (5).

Globally, adolescent mental health conditions account for a significant burden of disease (1,2). In socioeconomically disadvantaged communities, stressors such as poverty, limited educational access, and exposure to child labour further compound vulnerability (4).

Child labour remains a substantial global concern, particularly in low- and middle-income countries (4). In India, national child protection policies emphasize education and holistic development as protective factors (10). However, economic realities often normalize labour participation alongside schooling.

Peer influence plays a critical role in shaping adolescent risk behaviors, including substance experimentation (6,8). Life-skills education, including assertiveness training and emotional regulation strategies, has been recommended as an effective preventive approach (3,6).

This study aims to evaluate psychosocial well-being, educational aspirations, and decision-making capacities among preteens residing in a socioeconomically vulnerable setting.

Methods

Study Design

A cross-sectional descriptive survey was conducted.

Participants

33 Preteen children enrolled in local educational or community programs were included. Their age was in between 8 to 12 years.

Data Collection Tool

The questionnaire assessed emotional well-being, prosocial behaviors, autonomy, occupational aspirations, educational goals, problem-solving skills, peer pressure resistance, stress management, and anger regulation. Domains were selected based on established psychosocial development frameworks (3,5,7).

Data Analysis

Responses were analyzed descriptively using proportions and interpreted within existing psychosocial and developmental literature (5,8).

Results

Emotional and Social Well-being

The majority of participants reported positive affect and strong peer connections. Such findings align with global data suggesting resilience even within adverse environments (2,7).

Educational and Occupational Aspirations

Nearly all respondents expressed a desire to continue education, consistent with national and international emphasis on schooling as a protective factor (9,10). However, willingness to engage in helping parents brick kiln labour reflects the persistence of normalization of work in vulnerable communities (4).

Autonomy and Decision-Making

While many children demonstrated stress management confidence, some reported difficulty refusing uncomfortable situations, indicating potential assertiveness gaps. Peer-influenced risk-taking remains a documented concern during early adolescence (6,8).

Problem-Solving and Emotional Regulation

Most participants perceived themselves as capable problem-solvers. However, inconsistent anger regulation and endorsement of aggression as a conflict-resolution strategy highlight areas requiring intervention. Evidence supports structured life-skills programs to address such deficits (3,6).

Discussion

This study highlights the coexistence of resilience and vulnerability among preteens in socioeconomically constrained settings. Educational aspiration appears strong, reflecting policy-driven awareness and cultural valuation of schooling (9,10).

However, psychosocial skill gaps—particularly in autonomy and anger regulation—mirror findings from broader adolescent developmental literature (5,7). Peer-mediated risk behavior susceptibility underscores the importance of early preventive frameworks (6,8).

The World Health Organization advocates for life-skills education and structured psychosocial interventions to strengthen resilience and reduce risk behaviors (3,6). Integration of such programs into school and pediatric outreach services may offer sustainable impact.

Limitations

- Binary response format limits nuanced understanding.
- Small, localized sample restricts generalizability.
- Social desirability bias may influence responses.
- Future studies should incorporate validated psychosocial scales and qualitative interviews for deeper contextual insights.

Conclusion

Preteens in vulnerable communities demonstrate encouraging levels of educational motivation and social connectedness. Nevertheless, autonomy, emotional regulation, and peer resistance skills require strengthening. Evidence-based life-skills education and psychosocial interventions are recommended to promote holistic development and long-term well-being (3,6,7).

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Adolescent Health Clinics in Medical Colleges

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Introduction :

Adolescence, defined by the World Health Organization as the age group between 10 **and 19 years**, represents a critical transitional period marked by rapid physical, psychological, and social development. This stage is associated with increased vulnerability to various health issues such as nutritional deficiencies, reproductive and sexual health problems, mental health disorders, substance abuse, and risk-taking behaviours. Recognising the importance of adolescent health, the Government of India launched the **Rashtriya Kishor Swasthya Karyakram in 2014** under the National Health Mission to provide comprehensive adolescent health services nationwide. One of the key components of this program is the establishment of **Adolescent-Friendly Health Clinics (AFHCs)** at various levels of the healthcare system, including medical colleges, district hospitals, and community health centres.

Rationale For Establishing Adolescent Clinics In Medical Colleges:

Medical colleges occupy a strategic position within the healthcare system due to their role in clinical service, education, and research. Establishing adolescent clinics within these institutions can address several gaps in adolescent healthcare.

Key reasons include:

Specialised Care Availability -

Medical colleges provide multidisciplinary support, including paediatrics, psychiatry, gynaecology, dermatology, and nutrition, enabling comprehensive adolescent care.

Training of Healthcare Professionals –

These clinics can serve as practical training centres for undergraduate and postgraduate medical students, nurses, and counsellors.

Research and Evidence Generation –

Medical colleges facilitate research on adolescent health, helping generate evidence for better policy implementation.

Referral Centres -

Adolescent clinics in medical colleges serve as tertiary referral centres for complicated cases referred from primary and secondary healthcare facilities.

Practical Framework For Establishment Of Adolescentclinics –

Medical colleges occupy a strategic position within the healthcare system due to their role in clinical service, education, and research. Establishing adolescent clinics within these institutions can address several gaps in adolescent healthcare.

1. Infrastructure Requirements -

According to national AFHC operational guidelines, adolescent clinics should have dedicated and youth-friendly infrastructure that ensures privacy and comfort.

Essential infrastructure components include:

- Separate consultation room
- Private counselling room
- Examination room with privacy screens
- Waiting area with educational materials
- Clean drinking water and sanitation facilities
- IEC materials and signboards for awareness

A welcoming and adolescent-friendly environment is crucial toencourage utilisation of services.

2. Human Resources -

Adolescent clinics require a **multidisciplinary team** to address the diverse health needs of adolescents.

Key personnel include:

- Paediatrician or Medical Officer
- Gynaecologist (for adolescent girls)
- Psychiatrist or psychologist
- Trained adolescent health counsellor
- Staff nurse or ANM
- Social worker or peer educator

3. Package of Services –

Adolescent clinics provide a comprehensive package of services covering multiple domains of adolescent health.

Services covering:

- Clinical Services
- Preventive and Promotive Services
- Mental Health Services
- Sexual and Reproductive Health Services

These services address the key priority areas of adolescent health under RKSK, including **nutrition, sexual and reproductive health, mental health, substance misuse, non-communicable diseases, and gender-based violence.**

4. Operational Model –

Adolescent clinics in medical colleges generally function through a structured operational model:

Function covering:

- Dedicated clinic days or daily OPD services for adolescents
- Confidential registration and record keeping
- Referral linkages with specialised departments within the medical college
- Community outreach programs through schools and peer educators

Checklist For Adolescent Health Visit :

1. History from Parents and Adolescents
2. Separate questioning of Adolescents
3. Separate questioning of Parents
4. Physical examination
5. Counselling
6. Investigations
7. Referrals

Benefits Of Adolescent Clinics In Medical Colleges

1. Improved Access to Healthcare –

Adolescent clinics provide a safe and confidential environment that encourages adolescents to seek medical help.

2. Social and Cultural Barriers

Cultural stigma related to sexual and reproductive health issues may discourage adolescents from seeking care.

3. Inadequate Infrastructure

Some facilities lack dedicated space or privacy, which reduces the adolescent-friendly nature of the clinic.

4. Shortage of Trained Personnel

Limited availability of trained counsellors and sensitisedhealthcareproviders can affect service quality.

5. Confidentiality Concerns

Fear of breach of confidentiality may deter adolescents fromvisitinghealth facilities.

Establishment Of An Adolescent-friendly Health Clinic in India

Adolescent Friendly health clinic was established on 17 July, 2025 in the Pediatric OPD of the Department of Pediatrics, Government Medical College and the associated hospital, Datia (M.P). The clinic provides accessible, confidential, and non-judgmental health services to adolescents with unique physical needs through a comprehensive and curative service, including anaemia and transmitted infections, including menstrual and behavioural issues such as acne, and healthy aged 10–19 years, aiming to address the unique physical, psychological, and social health needs of adolescents through a comprehensive and youth-friendly approach.

Here we are providing a range of preventive, promotive, and curative services, including:

- Screening and management of nutritional disorders such asanaemiaand malnutrition.
- Counselling on sexual and reproductive health, includingmenstrual problems, contraception, and prevention of sexually transmittedinfections.
- Mental health counselling for stress, anxiety, depression, andbehavioural issues.
- Management of common adolescent health problems suchasacne, obesity, substance abuse, and lifestyle disorders.
- Health education and promotion regarding hygiene, nutrition, and healthy lifestyle practices.

Adolescent-Friendly Environment of the Clinic:

The clinic is designed to ensure:

- Privacy and confidentiality,
- Respectful and non-judgmental communication,
- Convenient clinic timings (12 pm – 2 pm),
- Confidential counselling

These features encourage adolescents to seek healthcare services without hesitation and promote trust, courage, and effective communication between adolescents and healthcare providers.

Enrollment of Adolescents:

A total of 34 Adolescents enrolled, including 16 adolescent girls and 18boys in G.M.C., Datia, M.P. These adolescents were registered during the study, received counselling, health screening, and preventive services as part of the clinic activities.

Activities Of Adolescent Friendly Health Clinic

Figure 1: Objectives of Adolescent Friendly Health Clinic, Guidelines for Adolescents and their parents.

Figure 2: Adolescent Immunisation Schedule, Nutritional Pyramid for Adolescents

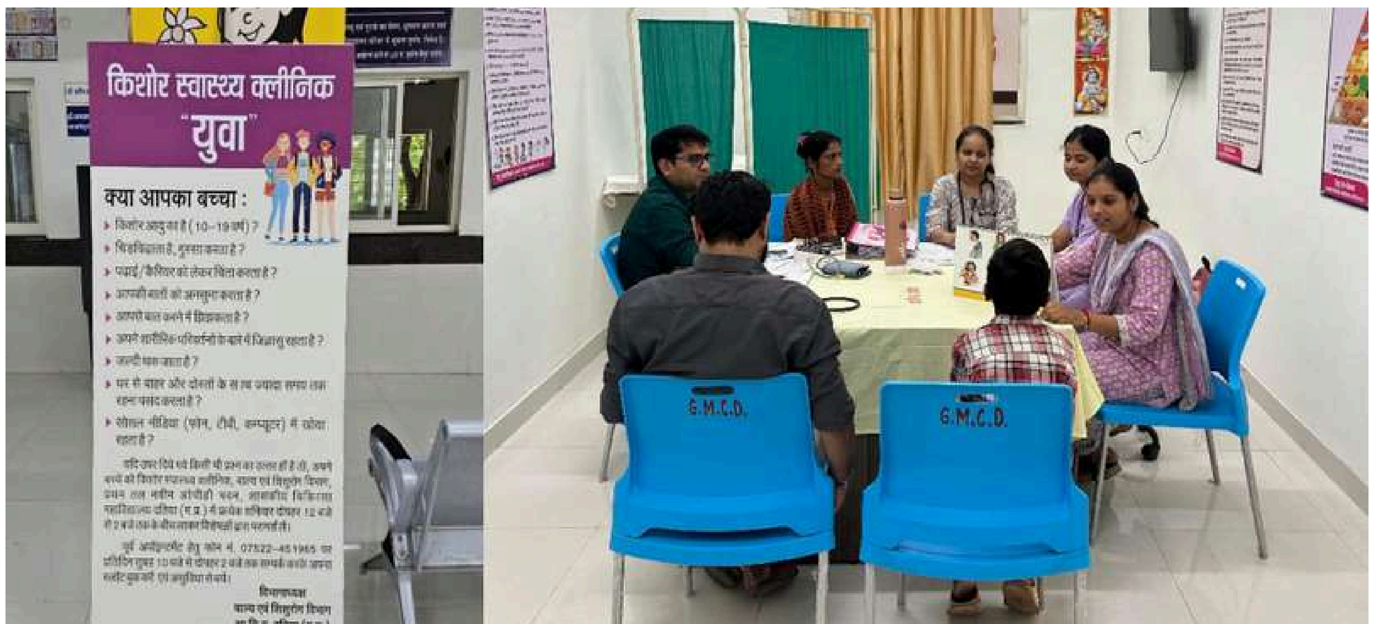

Figure 3: Adolescent Friendly Health Clinic in G.M.C., Datia,M.P.

The establishment of adolescent clinics in medical colleges is a crucial step toward addressing the diverse health needs of adolescents. These clinics provide a structured platform for delivering comprehensive healthcare services, promoting healthy behaviours, and facilitating early detection of health problems. Now this is the right time to start adolescent-friendly health clinics in medical colleges throughout the country for our adolescents, which are comprising almost 21% of the population (about 250 million), flag bearers of our Hon'ble Prime Minister's dream concept- Viksit Bharat 2047.

Link : https://drive.google.com/file/d/1EENacMqlNE6q_rOFaO20bYnOEAbudtE7/view?usp=sharing

Building capacity for adolescent health:

Perspectives on 'competence' and 'outcome' for teachers and learners

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Recently, in 2025, the WHO has published a document on competency and outcomes for training in adolescent health (1)

Competency is defined as an **observable ability to 'perform' a task.** To achieve health standards, we need to train health workers to be 'competent' and design training material accordingly. Components of competency include a knowledge base, practical skills, attitudes, and an ability to adapt to different real-life contexts in managing a patient.

For ex. When we want to train a person to be competent **'in eliciting a meaningful HEEADDSSS history from an adolescent,'** we need to list the 'specific learning objectives' (SLO) needed for the same.

This includes **Knowledge** *(of normal adolescent development, problems of adolescents, adolescent friendly approach needed to ensure privacy, confidentiality, legality, consent, etc.)*

Skills *(basic counselling skills by using practical role play demonstrations, opportunity to interview a pretend patient, feedback and refinement etc.)*

Attitudes *(nonjudgmental, encouraging, respectful, etc.)*

The session and activities should be designed to train on all these aspects, and finally the level of competence (observable behavior) of the trainee should be quantified by marks/certified as adequate to meet basic standards or more.

We share here the experience of conducting a **TOT workshop** at **St. John's Medical College Hospital** as part of the National Conference on Paediatric Education 2022. The workshop was titled; **Adolescent health: Strengthening faculty competencies to teach.** The trainees were faculty physicians from various departments who encounter adolescents in their practice and also train medical undergraduates and postgraduates. This workshop is referred to as an example in the chapter 'implementation frameworks' of the WHO document. (Box 3, ref 2) for competency-based training.

The current adolescent health training frameworks, even in medical colleges and teaching institutions, are scanty or nonexistent. Faculty trainers are themselves unfamiliar with managing adolescent problems and are on a self-learning curve. The workshop sought to fill this gap and facilitate faculty to acquire skills and be capable of implementing the curricular requirements for medical students, in addition to training other faculty members (all training material was shared with participants)

Box 3. Training of trainers: capacity-building for medical educators in Bengaluru, India

In Bengaluru, India, a workshop on adolescent health aimed to strengthen the capacity of medical teachers in preparation for the introduction of a competency-based undergraduate medical curriculum that included 13 competencies related to adolescent health.

The workshop involved case discussions, lectures, tutorials and groupwork sessions. Workshop topics included strengthening adolescent-friendly health services at the teaching facility through review of guidelines and an in-person visit to the clinic; teaching of counselling and the HEEADSSS assessment, SRH, medico-legal aspects of adolescent health and adolescent mental health; and teaching anticipatory guidance – including developing a checklist of topics such as sleep, diet and physical activity to be added to routine patient care documents.

Source: Adapted from Dinakar and Galagali *(30)*.

The participants were facilitated to develop SLO's for the listed 13 competencies in the UG curriculum as described in box 3. They witnessed a demonstration class on mental health and had an opportunity to use tools available in the Teen clinic. Bed side teaching on an adolescent case was used to demonstrate privacy, confidentiality, boundaries etc.

The learnings for all of us as we move forward are: to include competencies as endpoints for any training session, draw up a list of corresponding SLOs covering knowledge, skills, and attitudes to design the teaching and marking methods, thereby ensuring competency that is adaptable to real-life scenarios. That would be an ideal training workshop or class with the desired outcome for adolescent health.

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Self-Harm in Adolescents:

Case Studies from a Tertiary Care Hospital in Kashmir

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4. PG Resident 3rd Year

Introduction

Adolescent self-harm has emerged as a significant public health and mental health concern globally. Self-harm is defined as the intentional infliction of injury or poisoning, irrespective of suicidal intent --often representing a maladaptive coping response to psychological distress, emotional dysregulation, and adverse social environments. While not all acts of self-harm are associated with a desire to die (Non-Suicidal Self-Injury or NSSI), they are consistently linked to heightened risks of subsequent suicide attempts, psychiatric morbidity, and long-term psychosocial impairment.

The statistics are alarming: suicide is the fifth leading cause of death globally and the third leading cause of adolescent mortality in India. Every hour, one child dies by suicide in India (IAP).

"Every hour, one child dies of suicide in India." (IAP)

Adolescence is a particularly vulnerable developmental phase, marked by rapid biological changes, evolving identity formation, academic pressures, and shifting family and peer relationships. In low- and middle-income contexts such as India, these vulnerabilities are further shaped by educational stress, family conflict, limited mental health literacy, and restricted access to early psychosocial support.

This article examines patterns of self-harm ideation and behaviour among adolescents using case studies from a hospital-based study conducted at the Department of Pediatrics, GMC Srinagar.

Case Studies: Voices from the Ward

The following case studies, drawn directly from clinical evaluations, illustrate the complex and multifaceted nature of adolescent self-harm. They reveal the intersection of trauma, peer victimisation, academic pressure, digital influence, family conflict, and impulsivity that drives young people to crisis.

Case Study 1 : The Weight of Compounded Trauma (Girl, 16)

A 16-year-old girl was brought to the hospital after ingesting 12 tablets of Escitalopram and Clonazepam. On assessment, she revealed a deeply distressing personal history: she was a single child who had experienced sexual abuse during primary school. This early trauma was compounded by chronic peer victimisation — she was subjected to sexualised derogatory labelling by senior students. Unable to cope, she had begun smoking and using cannabis as early as Class 5.

When the clinical team visited her in the ward, she was in acute distress — pulling her hair, shouting, and throwing objects. Her body was shaking, and she kept demanding ketamine, stating it was her usual intervention during such episodes.

This case powerfully highlights the cumulative impact of early childhood trauma, chronic peer victimisation, bullying, identity disturbance, and mood dysregulation — a constellation of risk factors that, left unaddressed, culminated in a near-fatal overdose.

Case Study 2 : Self-Harm as Control (Boy, 14)

A 14-year-old boy was admitted after ingesting rodenticide. Once stabilised, a psychiatric evaluation led to a diagnosis of major depressive disorder; he was commenced on lithium. His history included early trauma — his father had died when he was young. However, the immediate trigger for his suicide attempt was a fight with his girlfriend.

"I have no regrets about taking the poison. I don't care if I die. But whenever I need something, I will again do the same thing." — 14-year-old patient

As an only child, he had been over-pampered throughout his upbringing, and tantrum-like behaviour had become part of his personality. Strikingly, he viewed self-harm not merely as a response to distress, but as a tool for secondary gain — a mechanism of control. This case underscores how deeply ingrained parenting patterns can inadvertently reinforce self-destructive coping behaviours.

Case Study 3 : When AI Becomes an Accomplice (Girl, 11)

An 11-year-old girl was brought to hospital after ingesting 30 paracetamol tablets. Following emergency intervention and psychological evaluation, she disclosed that she had been experiencing suicidal thoughts for six months. Her background included parental separation, a history of childhood sexual abuse (CSA), academic difficulties, and over-pampering.

In one of the most disturbing revelations of this study, it emerged that she had searched for methods of suicide using a generative AI chatbot.

She had entered the prompt: "How can I kill myself with the medicines present in my home already?" and received step-by-step instructions, including the use of multiple paracetamol tablets and having dry coffee, which she then followed.

This case is a stark warning for clinicians, parents, and policymakers about the unguarded risks of AI tools in the hands of vulnerable young people. It calls urgently for digital safety protocols and safeguards.

Case Study 4 : Honour, Shame, and Secrecy (Girl, 14)

A 14-year-old girl was admitted to hospital after rodenticide ingestion. Her parents initially described it as accidental poisoning. However, during a counselling session, the truth emerged: it was a deliberate suicide attempt. Her brother had discovered her secret romantic relationship and disclosed it to their parents, who then restricted her movements, confiscated her phone, and involved her boyfriend's family.

Unable to bear the perceived humiliation, she chose to attempt suicide. According to informants, her boyfriend had also attempted suicide around the same time and was admitted to a separate hospital illustrating how adolescent relationships, under social and familial pressure, can intersect fatally.

Case Study 5 : Honour Culture and Impulsivity (Boy, 14)

A 14-year-old boy was brought to hospital in critical condition after hanging himself. He was described by all who knew him as academically bright, lively, and universally liked. The precipitating event was an accusation by a friend: the boy was alleged to have hacked the friend's Free Fire gaming account, resulting in a loss of ₹40,000. His friend came to his home and created a public scene, following which his father beat him.

"This thing came upon my honour. When I am beaten, I cannot bear it." 15 year-old patient (translated from Urdu)

In a chilling second statement, he reflected on the impulsiveness of the act: "I had never had such a thought before. I went to the room, there was a rope, and I thought I would just hang myself because I was angry and wanted to teach my family a lesson." This case illustrates how brief, impulsive acts of self-harm triggered by shame and poor emotional regulation can be catastrophic.

Case Study 6 : Academic Shame and Suicidal Intent (Boy, 16)

A 16-year-old boy was admitted for organophosphate (OP) poisoning. He had failed two subjects in his Class 10 Board Examination. He was unambiguous about his intent — he had wanted to die, not merely harm himself.

“I should have had a larger amount of the poison so that I could have died. If I had died, it could have saved me from the humiliation and shame I faced in front of my family.” 16-year-old patient

This case is a sober reminder that many adolescent self-harm presentations carry genuine suicidal intent, and must not be dismissed as "attention-seeking."

Case Study 7 : Academic Pressure and Unheard Voices (Girl, 15)

A 15-year-old girl presented with OP poisoning. She was a Class 9 student enrolled at a NEET coaching centre. Unable to cope with the rigorous academic demands and intense competition, she had scored poorly on a test. She overheard family members expressing disappointment about the money being spent on her coaching.

“I try to study a lot, but I am not able to understand chemistry, physics and maths. My parents want me to become a doctor, but they don't understand how much I try.” — 15-year-old patient

Her words capture the silent suffering of countless adolescents caught between parental ambition and their own capacity — a pressure cooker dynamic that is, tragically, claiming young lives.

Interventions: The Clinical Response

For every adolescent presenting with self-harm or suicidal concerns at GMC Srinagar, a comprehensive, multi-disciplinary intervention is provided. The team comprising a Paediatrician, Child Psychiatrist, Clinical Psychologist, Counsellor, and Medical Social Worker initiates the following:

Comprehensive psychiatric assessment followed by weekly sessions with the patient and their caregivers. Supportive psychotherapy and Cognitive Behavioural Therapy (CBT) are used to help adolescents safely express and process their emotions.

Psychoeducation for parents on suicidal ideation, warning signs, and the critical importance of emotional validation. A personalised safety plan is developed with emergency contacts, helpline numbers (e.g., 1098), and strategies to manage future crises.

Relaxation techniques to address anxiety, emotional dysregulation, and impulsivity. Problem-solving skills training to build resilience. Referral to drug de-addiction centres where substance use is identified.

Follow-up is structured as weekly sessions for the first two months, monthly during the first year, and twice yearly in the second year.

The Role of Paediatricians

Paediatricians are often the first point of contact for adolescents and their families , a position of privilege that carries a responsibility to screen for mental health concerns at every visit. Using tools such as the HEEADSSS (or its modified version, SHADESSS) assessment framework, clinicians can sensitively explore Home environment, Education, Eating, Activities, Drugs, Sexuality, Suicide/Safety and related domains.

A simple, non-judgmental probe such as "Sometimes, when things get very difficult, young people think about hurting or even killing themselves. Have you had any such thoughts?" can open the door to critical conversations. If the screen is positive, risk should be stratified (low, moderate, or high) using validated tools such as the Columbia Suicide Severity Rating Scale (C-SSRS) or the IS PATH WARM mnemonic.

Paediatricians should also advocate for lethal means restriction ensuring that medications and other potentially dangerous items in the home are secured.

Conclusion

The cases presented here represent only the adolescents who reached a hospital and received an evaluation. The true burden of self-harm and suicidality in the community remains largely unexplored. Larger, community-based studies are urgently needed to understand the full scale of this crisis.

What this study makes unmistakably clear is that adolescent self-harm in Kashmir and across India is not a monolithic phenomenon. It emerges from the intersection of academic pressure, relational conflict, unresolved childhood trauma, digital influence, impulsivity, and a profound lack of safe spaces for young people to express distress.

The time has come for a national, comprehensive suicide prevention policy with a focused adolescent component. Paediatricians, schools, families, and policymakers must act together before the next child is lost.

Diagnosis and Management of Asthma in Children and Adolescents

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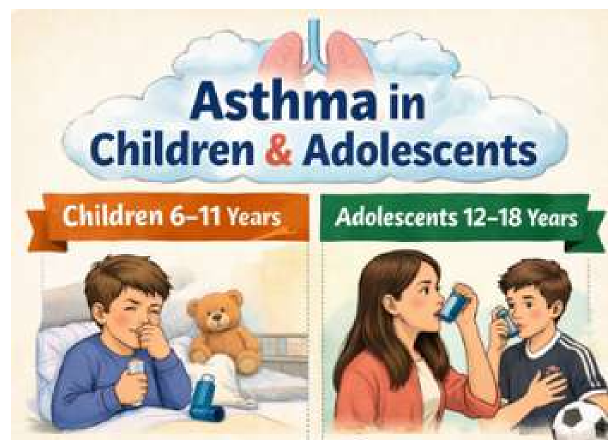
Identity Formation



Asthma is a chronic respiratory disorder characterized by airway inflammation and heterogeneous clinical phenotypes. It affects approximately 300 million individuals worldwide, with a rising prevalence in developing countries; Indian data indicate a prevalence of around 7.9% among children.

The disease imposes a significant burden on families and healthcare systems through limitations on daily activities & disruptions to schooling. Despite being a major cause of preventable morbidity and mortality, early initiation of appropriate therapy can substantially improve long-term disease control.

Cardinal Symptoms of Asthma

The clinical diagnosis of asthma is based on a history of characteristic, variable respiratory symptoms. The cardinal features include wheeze, dyspnea, chest tightness, and cough, with variability in frequency and intensity over time. Symptoms commonly occur or worsen at night or in the early morning and are often triggered by viral respiratory infections, exercise, laughter, cold air, or exposure to environmental allergens. Exercise-induced symptom exacerbation is a particularly suggestive feature. A personal history of atopic conditions such as allergic rhinitis or eczema, or a family history of asthma or allergy, further increases the likelihood of the diagnosis.

Establishing the Diagnosis

A diagnosis of asthma should be established prior to initiating long-term therapy and requires two key components: a history of variable respiratory symptoms and objective evidence of variable expiratory airflow limitation. Physical examination is often normal, although wheeze may be detected, particularly on forced expiration. Spirometry with bronchodilator reversibility testing remains the gold standard for confirming airflow limitation. According to GINA guidelines, a positive bronchodilator response is defined as an increase in FEV_1 or FVC of ≥12% and 200 mL in adolescents (12–18 years), and an increase in FEV_1 of ≥12% predicted in children aged 6–11 years.

In younger children who are unable to perform reliable spirometry, alternative approaches are recommended. Peak expiratory flow (PEF) measurements may demonstrate significant reversibility (increase >20% in adolescents and >15% in children) or excessive diurnal variability over two weeks (>10% in adolescents and >13% in children). Additionally, a clinically meaningful improvement in lung function following a 4-week trial of inhaled corticosteroids supports the diagnosis.

Forced oscillometry has emerged as a useful adjunct, particularly in children, as it assesses airway resistance without requiring active patient cooperation. However, standardized pediatric reference values remain limited. Suggested cut-offs for bronchodilator response include a decrease of ≥40% in R5, an increase of ≥50% in X5, and a decrease of ≥80% in AX.

Airway hyper-responsiveness can be assessed using bronchial provocation tests with agents such as methacholine, hypertonic saline, mannitol, or exercise. These tests have limited specificity, are infrequently required in routine practice, and are generally reserved for selected cases, such as suspected cough-variant asthma with normal spirometry. A significant decline in FEV_1 from baseline (e.g., >20% with methacholine or >10–12% with exercise challenge) is considered diagnostic.

In settings where spirometry or PEF is unavailable, Type 2 inflammatory biomarkers such as fractional exhaled nitric oxide (FeNO) and peripheral blood eosinophil counts may support the diagnosis in symptomatic individuals. However, these markers lack specificity and should not replace objective demonstration of variable airflow limitation.

Allergy testing, including skin prick testing and serum-specific IgE measurement, may help identify allergen sensitization and define the allergic phenotype, but it is neither necessary nor sufficient for diagnosis. Similarly, imaging studies are primarily useful for excluding alternative diagnoses or identifying comorbidities and should not be used as standalone diagnostic tools.

Differential Diagnosis

Several conditions can mimic asthma, and alternative diagnoses should be actively considered when objective criteria are not fulfilled. In adolescents presenting predominantly with chronic cough, important differentials include upper airway cough syndrome, chronic rhinosinusitis, gastroesophageal reflux disease, inducible laryngeal obstruction, and dysfunctional breathing. In low- and middle-income settings, endemic conditions such as tuberculosis, parasitic or fungal lung diseases, and HIV-associated pulmonary complications must also be excluded. In younger children, particularly those with atypical or persistent symptoms, evaluation should include the possibility of inhaled foreign body, bronchiectasis, congenital or acquired heart disease, and primary or secondary immunodeficiency disorders.

Initiation of Treatment

A key paradigm shift in asthma management is the recommendation that asthma should not be treated with as-needed short-acting β_2-agonists (SABAs) alone. SABA-only therapy fails to address underlying airway inflammation and is associated with poorer lung function, increased risk of severe exacerbations, and higher asthma-related mortality. Accordingly, all children and adolescents should receive inhaled corticosteroid (ICS)-containing therapy to reduce morbidity.

Maintenance-and-reliever therapy (MART), using an ICS–formoterol combination, involves both daily maintenance dosing and use of the same inhaler for symptom relief. This approach simplifies treatment and has been shown to reduce severe exacerbations more effectively than regimens using separate controller therapy with SABA as a reliever.

In children aged 6–11 years, treatment is escalated in a stepwise manner according to baseline symptom burden and control. Nocturnal awakening due to asthma is a practical marker of inadequate control and generally indicates the need for Step 3 or higher therapy. According to GINA recommendations:

- **Step 1 (infrequent symptoms):** Low-dose ICS should be taken concomitantly whenever a SABA is used.
- **Step 2 (symptoms 2–5 days/week):** Daily low-dose maintenance ICS with as-needed SABA.
- **Step 3 (nocturnal symptoms ≥1 time/week):** Options include low-dose ICS–LABA, medium-dose ICS, or very-low-dose ICS–formoterol as maintenance-and-reliever therapy (MART).
- **Step 4 (frequent nocturnal symptoms, reduced lung function, or recent exacerbations):** Medium-dose ICS–LABA or low-dose ICS–formoterol MART. Referral to a pediatric asthma specialist is recommended at this stage.

Leukotriene receptor antagonists, such as montelukast, may be considered as add-on therapy from Step 2 onwards. However, they are not preferred agents due to concerns regarding potential neuropsychiatric adverse effects.

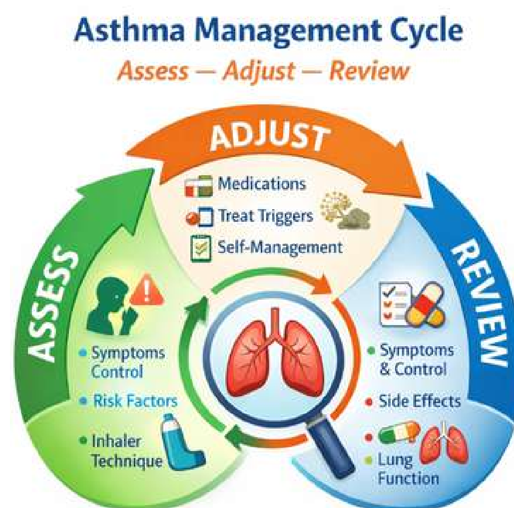
In adolescents (≥12 years), GINA recommends the use of low-dose ICS–formoterol as an anti-inflammatory reliever (AIR).

- **Steps 1–2:** Low-dose ICS–formoterol is used on an as-needed basis for symptom relief, significantly reducing exacerbations and emergency visits compared with SABA-only therapy.
- **Steps 3–4:** Maintenance-and-reliever therapy (MART) with low-dose and medium-dose ICS–formoterol, respectively, is recommended.

In patients with clinically significant aeroallergen sensitization, particularly those with coexisting allergic rhinitis, allergen-specific immunotherapy may be considered as add-on therapy due to its disease-modifying effects and sustained benefit on allergic responses. Preventive strategies should also include age-appropriate vaccination against influenza, pneumococcus, and pertussis, as these infections are common triggers for asthma exacerbations.

Follow-up

Asthma management follows a continuous "assess–adjust–review" cycle. Patients should be reassessed 1–3 months after initiation of therapy and subsequently at intervals of 3–12 months. Following an exacerbation, review within one week is recommended. Each visit should include evaluation of symptom control over the preceding 4 weeks, assessment of treatment-related adverse effects, and periodic measurement of lung function. Particular attention must be given to inhaler technique and medication adherence.



A written asthma action plan, including maintenance therapy, step-up strategies during exacerbations, and indications for urgent care, should be provided to all patients and caregivers. In patients with sustained control for 2–3 months, step-down therapy (reducing ICS dose by 25–50%) should be considered to identify the minimum effective dose. Current evidence does not support the routine use of sputum eosinophils or FeNO to guide treatment adjustments in children.

Poor control is frequently due to difficult-to-treat asthma driven by modifiable factors. Prior to treatment escalation, a systematic reassessment is essential, focusing on inhaler technique and adherence, confirmation of diagnosis through objective evidence of airflow variability or supportive biomarkers, and identification of environmental exposures or contraindicated medications.

Comorbid conditions may contribute to persistent symptoms or reduced treatment response. Allergic rhinitis and chronic rhinosinusitis commonly coexist with asthma, and their management with intranasal corticosteroids may improve overall control. Obesity is associated with poorer outcomes, and a 5–10% reduction in body weight can be beneficial. Treatment of gastroesophageal reflux disease should be reserved for symptomatic patients, as asymptomatic reflux is unlikely to affect asthma control. Although food is an uncommon daily trigger, confirmed food allergy significantly increases the risk of severe outcomes and necessitates a structured anaphylaxis management plan, including access to injectable epinephrine.

Allergic bronchopulmonary aspergillosis should be considered in patients with recurrent wheezing or poor response to therapy, as delayed recognition may lead to bronchiectasis. Management includes systemic corticosteroids and antifungal therapy in addition to inhaled corticosteroids.

Patients who remain uncontrolled after 3–6 months of optimized Step 4 therapy should be referred for specialist evaluation.

Phenotyping Asthma

Asthma phenotyping is indicated in patients with severe asthma, defined as disease that remains uncontrolled despite optimized high-dose ICS–LABA therapy and correction of modifiable contributory factors. At Step 5, patients should undergo specialist evaluation to characterize the underlying inflammatory phenotype. This assessment is based on Type 2 inflammatory biomarkers, including peripheral blood eosinophil counts, sputum eosinophils, and fractional exhaled nitric oxide (FeNO), to differentiate allergic, eosinophilic, and non–Type 2 asthma, thereby enabling selection of appropriate targeted biologic therapy.

Severe Asthma Management Options

In adolescents with confirmed severe asthma at Step 5, additional controller options are considered. Long-acting muscarinic antagonists (LAMA), such as tiotropium, may be added to ICS–LABA therapy, providing modest improvements in lung function and reduction in exacerbations.

Biologic therapies offer targeted treatment for specific inflammatory phenotypes and have demonstrated substantial efficacy in appropriately selected patients. Current options include:

- **Anti-IgE (omalizumab):** Indicated for severe allergic asthma (≥6 years).
- **Anti-IL-5/IL-5R (mepolizumab, benralizumab):** For severe eosinophilic asthma (mepolizumab ≥6 years; benralizumab ≥12 years).
- **Anti-IL-4R (dupilumab):** For Type 2/eosinophilic asthma (≥6 years).
- **Anti-TSLP (tezepelumab):** For severe asthma uncontrolled on high-dose ICS–LABA (≥12 years).

Chronic use of systemic corticosteroids should be avoided and reserved only as a last resort due to significant adverse effects, including adrenal suppression, metabolic complications, and osteoporosis.

Conclusion

Effective management of pediatric and adolescent asthma requires objective confirmation of diagnosis, avoidance of SABA-only regimens, and early initiation of inhaled corticosteroid (ICS)-based therapy. A structured approach emphasizing regular assessment of symptom control, optimization of inhaler technique and adherence, and systematic management of comorbidities is essential. In patients with severe, phenotyped asthma, appropriate use of targeted biologic therapies can further improve outcomes. Such an approach can substantially reduce disease burden, prevent exacerbations, and preserve long-term lung function in the pediatric population.

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Preteen Power!

Hello! I am **Riddhima Mishra** in class 8th. I recently attended a workshop with my mom and got to know that I am a pre-teen. I love being older as we get a lot of liberty and are old enough to get hobbies, do sports, learn new things etc. I love talking to my close friends and playing with my dog. This time is also when we develop in so many wonderful ways and figure out new interests.

Being a preteen is a very crucial stage of life. For our brain development and social life, I personally feel that it's really important to be socially aware and to believe in ourselves. Even though it's hard to do all the time, being honest with yourself is so important—especially when it comes to studies. When we stop making excuses and figure out what's actually going wrong, we give ourselves the best chance to improve and grow.

Many things such as studying, playing, friends and family are important to us. Me and my friends love music, it makes us calm. I believe that making good friends and maintaining a nice social circle is very important for our wellbeing.
If anyone troubles me, it's important to talk to a loved one and never keep it to ourselves thinking they will solve itself. If someone always At this age, along with balance we should also keep a positive mindset.

Regular physical exercise is also very important for a healthy body. Personally, I love to do karate. Karate built a structure of self-esteem, strength, and discipline within myself. Sports give people of all ages a sense of calm and focus, helping us feel stronger on the inside.

It's also important to keep track of our health in a positive way. Many preteens feel inferior about their looks and body. When my friends hear small comments from classmates, family or social media, it deeply affects them. As a friend, I like using kind, honest and supportive words to comfort them.

Being confident and always being positive can help all of us overcome these challenging years! Let's turn these years into an age of discovering something exciting about life. At the end I would like to say support your friends, stand up against bullying, do sports and I end here on a positive note!

Back to your arms

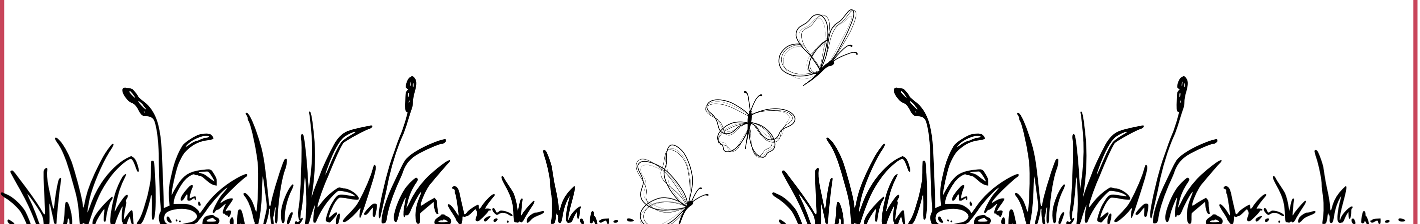
Riddhima Mishra | 12 Years | Agra

I wrote this poem to tell how growing up feels like. Now we could do Homework, walk, play and do stuff ourselves. But in our very distant childhood, when we were 2-3 years, I still remember those times when my dad told me his iconic stories.

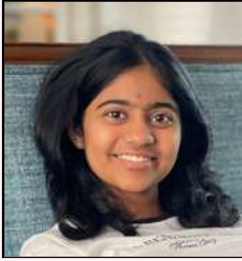
My mum would play with me and help me do all small tasks. My dadi used to feed me dal chawal with 'train aa rahi hai!'.
So many little moments! Now it just feels a bit more distant and I feel so much more far away from that.

I want to be little again to be adored and experience those little fun moments again..

Everyday I held your hand
With your help, I could partly stand
At night you tucked me, kissed my cheek
Only then I could patiently sleep
As I grew stronger and fine
I did not feel those little feet of mine
Brushing, bathing I could do
But distance between me and you flew
I want to hear those lullabies at night
Those magical wonderful stories so bright
Wake me again like you did when dawn
Then we'd go play all day in the lawn
Tuck me again when it was dusk
How you would feed me chai and rusk
I don't want to be further from you
How much I miss those times, I hope you have a clue



Metamorphosis



By Aarushi Rangole | 17 Years Old | Indore

This poem is a reflection of how I'm still discovering who I am, in the quiet in-betweens of life.
It's inspired by my emotions, my observations of people, and the belief that growth is a slow, beautiful process

I used to think identity was something solid —
a word you could underline,
a title you could place next to your name.
But lately it feels more like water.
Something shifting.
Something still forming.

I move through the world quietly sometimes,
watching more than speaking,
collecting small moments the way some people collect photographs-
a passing expression,
a pause in someone's voice.

I feel things deeply.
Not always gracefully.
Not always easily.
Sometimes it makes the world heavy.
but sometimes it also makes it beautiful.

I notice the parts of people that don't fit into simple stories-
the kindness behind someone's guardedness,
the doubt hidden inside confidence,
the light that exists beside every shadow.

Maybe that's why people talk to me.
Why they leave pieces of their stories in my hands.
I don't rush to judge them.
I sit with their words.
I try to understand the spaces in between.
I'm still learning who I am inside all of this.

I know I believe in fairness —
in the quiet strength of empathy,
in the idea that no one should be reduced to their worst moment.
I know I care deeply about the voices of women —
about the right to speak, to grow, to exist without shrinking.

But so much of me is still unfolding.
I connect easily with people,
yet trust grows slowly inside me —
like something that needs time,
and patience,
and a place where it feels safe to breathe.

Some days I feel strong.
Some days I feel soft.
And most days I am both.
And maybe that's what becoming looks like —
not a finished definition,
not a perfect certainty,
but a person standing somewhere in the middle,
holding curiosity in one hand
and self-discovery in the other,
learning, little by little,
how to become herself.

Adolescent Talent Hunt

Inchara Chidananda

Inchara is an 11-year-old student of Class 6 from Bengaluru who, apart from academics, has a genuine interest in art and creativity. She enjoys painting and is also learning Bharatanatyam. What began as a simple hobby has slowly grown into something she now pursues with passion.

Much of what she has learned comes from her own curiosity and practice rather than formal training, making her journey of learning all the more meaningful.

Shaarav Sanjeevkumar Kalkekar

Running with Purpose – 9 Marathons by Age 12

Shaarav Sanjeevkumar Kalkekar, a 12-year-old student of Delhi Public School, Navi Mumbai, has successfully completed 9 organized marathon events within the past year, participating across 1 km, 3 km, 5 km, and 10 km categories and earning medals in each run. His participation includes events such as the SBI Green Marathon Mumbai (10 km) and Thane Half Marathon (10 km), along with several city runs promoting causes like breast cancer awareness, organ donation, thalassemia prevention, environmental responsibility, and fitness.

Son of Dr. Sanjeevkumar Kalkekar, Interventional Cardiologist, and Dr. Shruti Kalkekar, Consultant Pediatrician and Adolescent Health Expert, Shaarav's steady progression reflects discipline, endurance, and social awareness.

His journey highlights the importance of physical fitness and community engagement in an era of increasing sedentary lifestyles among adolescents.

Mahi Singh

Painting is a wonderful way for Mahi, a 15-year-old class 11th student from Indore, to relax and express her creativity. In her free time, she enjoys sketching and bringing her ideas to life with colors on paper. Art gives her a quiet space to unwind after a busy day of studies and activities. Along with painting, Mahi also loves playing badminton, which keeps her active and energized. Through art and sports, she learns focus, discipline, and balance.

Mahi is the daughter of Dr. Isha Singh, a pediatrician, and Dr. Pranay Singh, an ophthalmologist, who warmly encourage her interests. With their support, she continues to explore her talents with joy and confidence.

Age - 15 years old | Male

Q : Would I be able to live with the expectations of my parents or teachers?

Expert Response: Feeling pressured by expectations from parents or teachers is quite common during adolescence. In most cases, these expectations come from their desire to see you succeed. However, it is equally important that your own interests and abilities are recognized. Try to keep communication open with your parents and teachers about your goals and challenges. With time and understanding on both sides, expectations can become more balanced and supportive rather than stressful.

Q : Would I be able to do what I wish to do in my future?

Expert Response: Your future depends on a combination of your interests, skills, efforts, and opportunities. Many young people do go on to pursue careers that match their passions, but it requires dedication and preparation. At your stage, the best approach is to focus on learning, exploring different areas of interest, and building strong skills. As you grow older and gain clarity about your strengths, you will be better able to shape the future you want.

Q : While studying, I get distracted by thoughts like how I can become more handsome or when I will buy my own new car?

Expert Response: Such thoughts are very common during the teenage years. Adolescents often begin to think more about their appearance, lifestyle, and future achievements. However, when these thoughts interfere with studying, it helps to practice simple concentration strategies such as studying in short, focused sessions, taking brief breaks, and limiting digital distractions. Remember that goals like financial independence and lifestyle choices usually become achievable after building a strong educational and skill foundation.

Age - 11 years old | Female

Q : I have the following queries:

- Why does my sister tell me not to watch YouTube shorts?

Expert Response: Your sister is likely trying to protect your focus and habits. Short videos like YouTube Shorts are designed to be very fast and engaging, which can make your brain get used to quick entertainment. Over time, this may make it harder to concentrate on studies, reading, or activities that require longer attention. Limiting such content helps your brain stay balanced and improves your ability to focus on important tasks.

- Why is my mother so strict about my screen time?

Expert Response: Parents often set limits on screen time because they care about your health and development. Too much screen use can affect sleep, reduce physical activity, and strain your eyes. It can also impact your concentration and mood. By setting boundaries, your mother is helping you maintain a healthy routine that includes study, play, rest, and family interaction—all of which are important for your overall growth.

- What should I do to improve my immunity and fall sick less often?

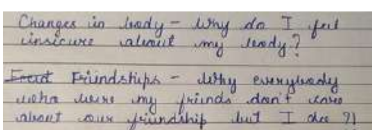
Expert Response: Improving immunity involves building healthy daily habits rather than relying on any single remedy.

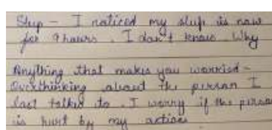
You can stay healthier by:

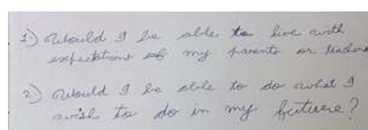
• Eating a balanced diet with fruits, vegetables, and protein-rich foods
• Staying physically active and playing outdoors
• Getting adequate sleep
• Maintaining good hygiene, such as regular handwashing
• Following your doctor's advice on vaccinations

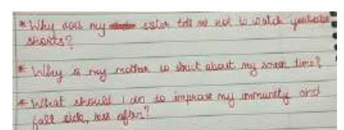
These simple habits help your body become stronger and better able to fight infections.

Taking small, consistent steps towards a healthy lifestyle can make a big difference over time.









Age - 10 years old | Female

I am 10 years old. Sometimes when I am just sitting idle, I suddenly feel irritated or angry without any reason. Why does this happen? Also, during competitions, I try very hard but my friend wins and I don't. That makes me feel very pressurised. Why do I feel like this?

Expert Response: What you are experiencing is completely normal for your age, and many children feel the same way, even if they don't always talk about it.

When you are sitting idle, your mind is still very active. At your age, your brain is learning how to understand and manage emotions. Because of this, feelings like irritation or anger can sometimes come up suddenly, even when there is no clear reason. It simply means your mind has extra energy or thoughts that need an outlet.

Regarding competitions, it is natural to feel disappointed when you try your best and do not win. You may also start comparing yourself with others, which can make you feel pressured. These feelings do not mean you are not capable—they simply show that you care about doing well.

It is important to remember that success is not only about winning. Every time you participate and put in effort, you are learning and improving. Your abilities grow with practice, patience, and self-belief.

If you feel upset, try talking to someone you trust, engaging in an activity you enjoy, or reminding yourself that doing your best is more important than the final result.

Growing up includes learning to understand your feelings—and you are already taking a great step by asking this question.

Age - 11 years old | Female

Q : There is a blackening in the vagina. Is it normal??

Expert Response: Yes, this is completely normal. During puberty, the body undergoes many hormonal changes, and it is common for the skin around the vaginal area to become a little darker.You may also notice hair growth in that region—this is a natural part of growing up.

Remember: Everybody is different, and these changes are healthy and expected. There is no need to use any creams or treatments.

If you notice itching, pain, or unusual discharge, then it's best to consult a doctor

Q : I feel very attracted to my friends and love talking to them on the phone. Is it good? Is it natural? Sometimes I enjoy it a lot, but at times I get irritated with their nonsense talk. How should I deal with this?

Expert Response: At your age, friendships become very special. Wanting to talk, share, laugh, and spend time with friends is an important part of growing up. It helps you feel connected, understood, and happy.
So yes—enjoying conversations with friends is both good and healthy.

What can you do?
- Talk and enjoy when it makes you happy
- Take a break when you feel bored or irritated
- Politely end the call if needed

How to handle both feelings
- ***Listen to your feelings:*** If talking makes you feel happy, continue. If you start feeling bored or irritated, it's okay to take a break.
- Set gentle limits: You don't have to be on the phone all the time. Decide a comfortable time limit for yourself.
- ***Learn polite ways to pause conversations:*** You can say things like, "I'll talk later, I need to finish something," or "Let's continue this tomorrow."
- ***Choose meaningful conversations:*** It's okay to enjoy fun chats, but you can also guide conversations towards topics you like.

Remember: Friendships should make you feel happy, relaxed, and comfortable—not tired or irritated all the time. Learning when to engage and when to step back is an important life skill.

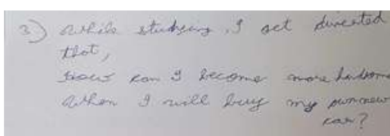
You are already doing well by noticing your feelings—just continue to trust them and take small, balanced steps.

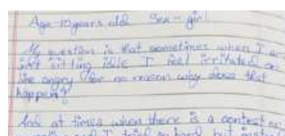
Age - 11 years old | Female

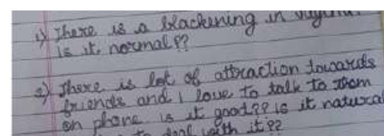
Q : I have noticed that I now sleep for around 9 hours. I don't know why. Is it okay?

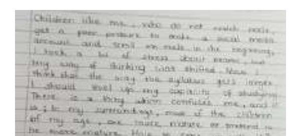
Expert Response: Yes, this is completely normal. During adolescence, your body goes through rapid growth and hormonal changes, which increase the need for rest. Sleeping for 8–10 hours is healthy at this age.

Remember: Good sleep helps in better concentration, mood, and overall development. Maintain a regular sleep routine and avoid excessive screen time before bed.









Q : I tend to overthink about the last person I spoke to and worry if I have hurt them. Why does this happen and what should I do?

Expert Response: This happens because you are emotionally aware and empathetic, which is a positive quality. As you grow, you become more sensitive to others' feelings and relationships. However, overthinking can make you anxious.

What can you do?

- Remind yourself that not every thought or conversation causes harm
- If you feel unsure, you can simply clarify or apologise
- Distract your mind with other activities instead of repeatedly thinking about it

Remember: Caring for others is good, but it is equally important to set emotional boundaries and not be too hard on yourself.

Age - 11 years old | Female

Q : Children like me, who do not watch reels, get peer pressure to make a social media account and scroll on reels. How should I deal with this?

Expert Response: First, understand that not following the crowd is actually a strength, not a weakness. Many children start watching reels just to fit in, not because it truly adds value to their lives.

You can handle this in three simple ways:

- Be clear about your choice: You can say, "I'm trying to avoid it because it distracts me." Most people respect clarity.
- Limit exposure, not friendships: You don't need to disconnect from friends—just don't adopt habits that don't suit you.
- Find your own space: Engage in something meaningful—sports, reading, or a hobby. When you're confident in your routine, peer pressure reduces automatically.

Remember, trends change fast, but self-discipline and focus always stay valuable.

Q: In the beginning I took a lot of stress about exams, but now I feel that as the syllabus increases, I should increase my capacity to study. Is this thinking correct?

Expert Response: Yes, this is a very mature and growth-oriented way of thinking.
Instead of fearing a bigger syllabus, you are choosing to upgrade yourself—this is exactly how successful learners think. However, keep a balance:

- Increase your study capacity gradually, not suddenly
- Focus on quality over quantity (understanding concepts rather than just hours)
- Include breaks and rest, because the brain needs recovery to perform better

This mindset shifts you from stress mode → growth mode, which is the healthiest way to approach academics.

Q: In my surroundings, most children of my age seem more mature or pretend to be more mature. This confuses me. How should I cope with it?

Expert Response: What you are noticing is very common during adolescence. Many children either:

- Actually develop at different speeds, or
- Pretend to be mature to fit in or feel accepted

Here's how you can deal with it:

- Do not compare timelines: Emotional and mental maturity grows differently for everyone
- Focus on being real, not impressive: True maturity is about clarity, kindness, and responsibility—not showing off
- Observe, don't absorb everything: Learn good things from others, but don't copy blindly

Sometimes, the one who is quietly thinking and questioning—like you—is actually more mature than the ones pretending.

Our Experts

Dr. Piyali Bhattacharya
drpiyali@gmail.com

Dr. Poonam Bhatia
doctorpoonambhatia@gmail.com

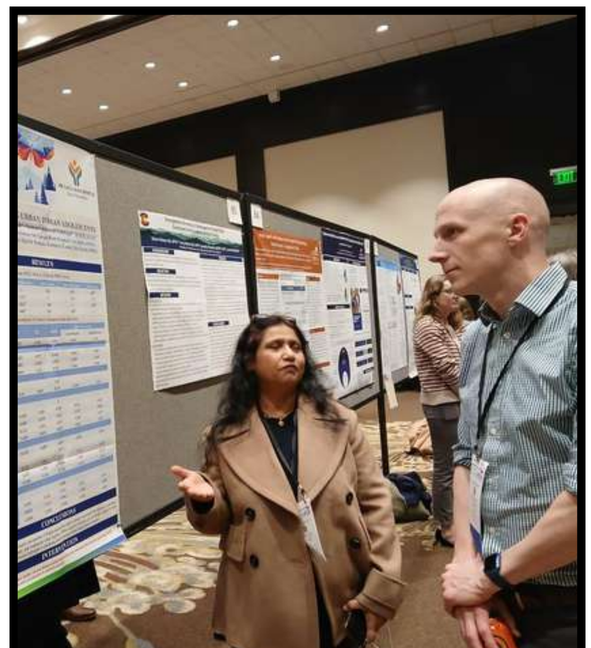
Spotlight on AHAians

We are delighted to share proud moments from the **Annual Society for Adolescent Health and Medicine (SAHM) Conference,** held from **3rd to 6th March 2026** in Seattle, USA. **Dr. Preeti Galagali** represented India with distinction as the only Indian faculty member at the conference.

She delivered insightful sessions across four key areas—adolescent vaccination, youth engagement workshops, social media use, and International Adolescent Health Week—bringing critical adolescent health issues to the forefront on a global stage. Adding to this achievement, **Dr. Latika Bhalla** made history as the first Indian pediatrician to present a poster at the **SAHM conference.**

Her work on adolescent sleep issues was widely appreciated and marks an important milestone.

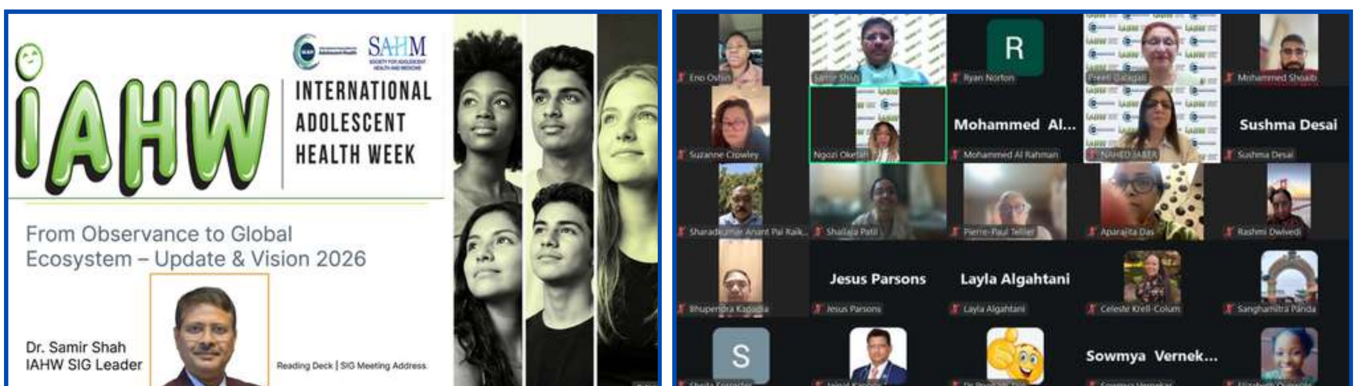
These accomplishments reflect the growing global presence and impactful contributions of our own AHA stars in the field of adolescent health.



Dr. Shubhada Khirwadkar has been honored with the Excellence Award in Healthcare and Social Service in recognition of her outstanding contributions to adolescent care. Through her dedicated work, she has consistently addressed the unique physical, emotional, and social health needs of young people, creating supportive and responsive care environments.

She describes receiving this award as a deeply personal and humbling moment

Dr. Samir P. Shah, serving as Global Lead for International Adolescent Health Week (2024–2026), played a pivotal role in the February 11 international committee meeting, where he not only presented a comprehensive review of IAHW 2025 but also articulated a visionary roadmap for 2026 demonstrating strong leadership and a forward-thinking approach to advancing global adolescent health initiatives.



AHA PEDICON 2026

Pre Conference Workshop - The Pre Teen Module Under Central AHA Action Plan of Dr. Sushama Desai, Chairperson 2026

A Pre-Teen Module was launched at PEDICON 2026, Kolkata, under the leadership of Dr. Sushma Desai. With the theme "Catch Them Early, Keep Them Safe," it focused on the holistic well-being of 8–12-year-olds, covering physical growth, mental health, digital well-being, and cyber safety.

Installation of New team of AHA with Dr. Sushama Desai, as AHA Chairperson 2026

Dr Rashmi Gupta had a session on LARC (long acting reversible contraceptive) used in adolescents is a sensitive issue in India due to the stringent POCSO Act and diverse cultural and religious values.

PEDIकON
2026

PEDIकON2026

Managing menstrual irregularities in Adolescents: PCOS,Anovulation & beyond

ASK THE EXPERTS

Chairperson:Dr Indrani Mitra , Dr Kajari Sarkar

MODERATER

1.30 Pm to 2.30 Pm
Date : 17 th Jan ,Sat
Hall no 4

DR SUSHMA DESAI

PANELISTS

DR ALKA SINGH
DR SANGITA LODHA
DR SAVITA CHOUDHARY

Dr. Harish Pemde, Dr. Kusum Kalla, Dr. Sonia Bhatt, Dr. Chitra Kulkarni, at AHA Panel discussion on “Gender, Body Image & Identity Development”

Dr. Geeta Patil - On Academic Pressure & Mental Health: Pandemic Fallout In School System.

Dr. Amog Shahane - On Adolescent Nutrition & Fitness.

Dr Shamik Gosh - On Breach of Confidentiality: A Case Study

Dr. Sangita Lodha and Dr. Piyali Bhattacharya receiving Presidential Appreciation Awards at PEDICON

Dr. Sawati Ghate was felicitated as a co-author with Dr. Vaman Khadilkar Sir and team: "IAP Revised guidelines on Evaluation, Prevention and management of childhood obesity", is one of the five most cited papers of 2024 IP

Exemplary Contribution to Child and Adolescent Health and IAP in 2025

Upcoming Events

HERE ARE SOME GREAT EVENTS HAPPENING THIS YEAR THAT YOU MIGHT BE INTERESTED IN:

1. 11th April 2026 | 9:00–10:00 PM IST (Online)
   Neuroscience of Mental Wellness In Children & Adolescents

2. 16th April 2026 | 3 – 4:30 PM (Online); then every (3rd Thur) monthly.
   PG PEARLS *Education Module- 2nd Edition*

3. 20th April 2026 | 8:30 - 9:30 PM (Online)
   Inauguration of Inter-Chapter Webinar

4. 21st April 2026, 8:30 PM - 10 PM (Online); then every (3rd Tue) monthly.
   1st Inter Chapter Webinar with NEURODEVELOPMENT CHAPTER

5. 30th April 2026 | 1st & 2nd May | 8 - 10 PM (Online)
   Capacity Building Workshop for Preteens Paediatricians Module

6. 10th May 2026 (Physical Event)
   NORTH ZONE CME BY HARYANA AHA *at Kurukshetra*

7. 22nd May 2026 at BANGALORE PEDICON (Physical Event)
   Preteen Module for Paediatricians by KARNATAKA AHA

7. 13th and 14th June 2026 at MGM Medical College, Kamothe, Raigad
   MAHAAHACON *by* MAHARASHTRA AHA *at Raigad*

AHA 2026

Communication links

Dear AHA 2026 Teammates, for smooth coordination and efficient functioning, kindly note and keep handy the following official AHA contacts, links & forms

01 **Official Central AHA Email**
iapahaindia@gmail.com

02 **AHA New Membership Application Form**
https://forms.gle/HKZp63AYcja4wfF96

03 **Official AHA Website**
https://aha.iapindia.org

04 **Instagram**
www.instagram.com/central.aha

05 **Instagram**
www.facebook.com/aha.central.2025

We kindly urge all members to save these important links and use them consistently for all official communications.

Together, let's make AHA 2026 more connected, visible & impactful.
Thank you for your cooperation!

Dr. Sushma Desai
Chairperson IAP AHA 2026

Dr. Shamik Ghosh
Secretary IAP AHA 2026

Dr. Prashant Kariya
Joint Secretary IAP AHA 2026

Dr. Samir Shah
Digital Media Committee Incharge

ADOLESCON 2026

26th National Conference of Adolescent Health Academy

CAHA - Jaipur AHA (In Association with IAP Rajasthan & Jaipur)

Theme: **Redefining Adolescent Care: From prevention to management**

27th - 29th NOV, 2026 | Rajasthan International Center (RIC) Jaipur

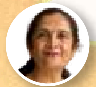
WHERE CUTTING-EDGE ACADEMICS MEET HANDS-ON SKILL ENHANCEMENT

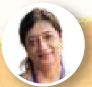
Registration Details

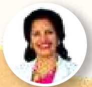
Registration Category	1st Apr - 30th Jun	1st Jul - 30th Sep	1st - 31st Oct (₹)	From 1st Nov / Spot (₹)
AHA / IAP Member (Life / Affiliated Member)	5000	6000	7000	7500
Non AHA - Non IAP Member	5500	6500	7500	8000
PG Student (IAP Membership required)	4000	5000	6000	7000
Senior Members Above 70 Years (AHA/IAP Members Only)	4000	5000	6000	7000
Accompany Person	4500	5500	6500	7500
Corporate Registration	-	-	-	8000

*** Above fee is inclusive of GST (18%)**

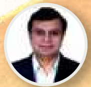
पधारो म्हारे देश


DR. SUSHMA DESAI
CHAIRPERSON, 2026


DR. PIYALI BHATTACHARYA
CHAIRPERSON ELECT, 2026

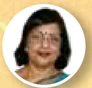

DR. HIMABINDU SINGH
IMMEDIATE PAST CHAIRPERSON, 2026

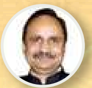
DR. SHAMIK GHOSH
SECRETARY, 2026

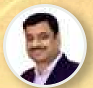

DR. DEEPAK GAUTAM
TREASURER, 2026

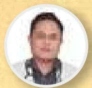
DR. S SITARAMAN
CHIEF ADVISOR

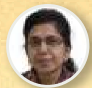
DR. ALOK GUPTA
CHIEF CONVENOR


DR. GEETA BANSAL
ORGANISING CHAIRPERSON


DR. TARUN PATNI
ORGANIZING CHAIRMAN


DR. S P SETHI
ORGANIZING SECRETARY


DR. MOHIT VOHRA
CONFERENCE TREASURER


DR. SWATI GHATE
SCIENTIFIC CHAIRMAN

Scan
HERE TO REGISTER

CONFERENCE SECRETARIAT

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Sethi Hospital
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Mob: 9829099701
E-Mail: adolescon2026@gmail.com | jaipuraha@gmail.com

Warm Regards

Organising Committee, ADOLESCON 2026